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Running Head: A SYSTEMATIC DEVELOPMENT OF A RESOURCE MANUAL

Pepperdine University  
Graduate School of Education and Psychology

PROVIDING HOPE: A SYSTEMATIC DEVELOPMENT OF A RESOURCE MANUAL FOR  
MENTAL HEALTH PROFESSIONALS TREATING LATINO/A ADOLESCENTS WITH  
SUICIDAL IDEATION

A dissertation submitted in partial satisfaction of the  
requirement for the degree of Doctor of Psychology

by

Rebecca Gutierrez, MA

May, 2017

Carrie Castañeda-Sound, Ph.D. - Dissertation Chairperson

# A SYSTEMATIC DEVELOPMENT OF A RESOURCE MANUAL

This dissertation, written by

Rebecca Gutierrez

under the guidance of a Faculty Committee and approved by its members, has been submitted to  
and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Dr. Carrie Castañeda-Sound, Ph.D., Chairperson

Dr. Robert deMayo, Ph.D.

Dr. Rosie Zapata-Martinez, Psy.D.

# A SYSTEMATIC DEVELOPMENT OF A RESOURCE MANUAL

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# A SYSTEMATIC DEVELOPMENT OF A RESOURCE MANUAL

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DEDICATION

This work is dedicated to my mother, Patricia Enríquez. She has always been my support to push myself to meet my full potential. She is my inspiration to always give back to our community.

In memory of Leopoldo González and Ramiro M. Gutiérrez.

Este proyecto está dedicado a mi madre, Patricia Enríquez. Ella siempre ha sido mi apoyo para trabajar a mi máximo potencial. Ella es mi inspiración para valorar, recordar, y abogar por nuestra comunidad.

En memoria de Leopoldo González y Ramiro M. Gutiérrez.

## ACKNOWLEDGEMENTS

I would first like to thank my dissertation chair, Dr. Carrie Castañeda-Sound for her indelible support throughout this process. This started out as a passionate topic I wanted to expand, and with her guidance, I was able to develop this idea into something that we knew was a much-needed resource in our community. Her feedback and positivity helped me grow as a clinician and researcher in the field. For that I am truly grateful.

I would like to acknowledge and thank my dissertation committee members, Dr. Robert deMayo and Rosie Zapata-Martinez for their incredible encouragement and constructive feedback throughout this process. Their expertise, combined with their genuine passion in providing quality care to all communities, have made this process an invaluable experience.

## VITA

**Education**

Pepperdine University, Graduate School of Education and Psychology  
Los Angeles, CA  
Doctorate in clinical psychology  
September 2011–August 2016

Pepperdine University, Graduate School of Education and Psychology  
Los Angeles, CA  
Master of Arts in Psychology  
September 2009–April 2011

University of California, Santa Barbara  
Santa Barbara, CA  
Bachelor of Arts in Anthropology with a Cultural Emphasis  
September 2002–June 2006

**Clinical Experience**

Children's Hospital Los Angeles/USC University Center for Excellence in Developmental Disabilities (APA Accredited)

Los Angeles, CA  
July 2015—June 2016

*Pre-doctoral Intern*

*Setting: Community Mental Health/Pediatric*

**Primary Rotations**

- *Assessment, Consultation, and Evaluation Rotation*
  - Specialization placement focusing upon psychological assessment approaches with children and adolescents and their families
  - Receiving supervised training in the psychodiagnostic and neurodevelopmental assessment within a variety of interdisciplinary clinics, such as the School-Aged Medication Evaluation Clinic and the Foster Care Hub
  - Strong interdisciplinary collaboration with other providers, including psychiatrists, developmental behavioral pediatricians, Occupational Therapists, Speech and Language Pathologists, and Physical Therapists
  - Leadership as a team coordinator for team meetings and consultations for new medication referrals
  - Provide case management support and advocacy by collaborating with patients' schools, social workers, and case coordinators, such as attending IEP's and accessing services through Regional Center
- *Child and Family Assessment Rotation*
  - Develop competency in psychological assessment, including battery development, administration, scoring and interpretation, of a range of complex diagnostic issues among children and adolescents

- Assessment referrals include children with co-occurring developmental disabilities (e.g., ASD and intellectual disabilities), mental health/behavioral concerns, chronic medical conditions, learning disabilities, exposure to trauma, and psychiatric diagnoses
- Provide feedback of assessment results with diagnostic impressions and recommendations to referring therapist and patient's family
- *Child and Family Therapy Rotation*
  - Training and supervision in psychological intake and assessment, treatment planning and intervention, with a focus on Evidence-Based Practices
  - Gaining experience in individual and family psychotherapy, group therapy, consultation, community and school involvement
  - Co-leading The Incredible Years child group
  - Participating in the California Leadership Education in Neurodevelopmental Disabilities (CA-LEND)

### **Graduate Psychology Education HRSA Funded Rotations**

- *Primary Care Rotations:*
  - Shadow primary care pediatrician, inpatient psychiatry, and obesity prevention groups
- *Specialty Care Rotations:*
  - Shadow pain and craniofacial clinics, transyouth support group, and outreach for homeless youth

Children's Hospital Los Angeles

Los Angeles, CA

August 2014—June 2015

*Doctoral Practicum Externship/Trainee*

*Setting: Pediatric Hospital, Department of Hematology and Oncology*

- Provide inpatient and outpatient individual therapy for children and adolescents in the Department of Hematology and Oncology
- Facilitate support groups for adolescents on the Inpatient Hematology and Oncology Unit
- Assist primarily Spanish-speaking patients with cancer or blood disease and their families' successful transition to school settings through the School Transition and Re-Entry Services (STAR) Program.
- Facilitate process group for young adults ages 19 and up who received or are receiving treatment for cancer and/or blood disease through the Teen Impact Program
- Recruit patients and families to participate in support group opportunities and additional programs
- Coordinate health and school needs through collaborating with the multidisciplinary team including doctors, social workers, and schools to form engaging multidisciplinary team
- Attend Individualized Education Plan (IEP) meetings and school consultations to provide recommendations of patients' needs to succeed in school
- Advocate for and provide psychoeducation to patients and families about procedures regarding special education, Individualized Education Programs, and Section 504 of the Rehabilitation Act

- Provide staff and student presentations at patients' schools to provide psychoeducation about patient's specific illnesses and needs
- Attend medical team meetings to review conditions of individual therapy and STAR patients.

Pepperdine Community Counseling Center

Los Angeles, CA

September 2013—August 2014

*Peer Supervisor*

*Setting: Community Mental Health*

- Professionally mentored and provided support to first and second-year doctoral-level students who entered a new clinical setting
- Attended case consultations to review and provide feedback to peer supervisees
- Reviewed charts, including notes and intakes, of peer supervisees to ensure appropriate and ethical therapeutic application and documentation
- Participated in clinic program development projects and quality assurance discussions to facilitate a positive experience for supervisees at school-based sites
- Co-facilitated group supervision to provide additional support for supervisees in school-based settings
- Created and led a couples therapy workshop to enable first-year students to conduct appropriate intakes, and intervention strategies

Ventura Youth Correctional Facility

Ventura, CA

August 2013-July 2014

*Doctoral Practicum Externship/Trainee*

*Setting: Forensic*

- Provided individual and group therapy to incarcerated youth, with primary focus on anger management, substance abuse, and criminal thinking
- Administered, scored, and interpreted cognitive and personality assessment batteries to provide integrative reports on diagnostic information and treatment recommendations
- Developed and facilitated crisis intervention group to provide psychoeducation about identifying and coping with crises for youth with a history of self-harm
- Co-facilitated anger management, life skills, and substance abuse groups to offer psychoeducation and to increase insight into maladaptive coping mechanisms
- Communicated with a multidisciplinary team of correctional officers, teachers, and psychiatrists to gain insightful information about youths' overall progress
- Attended and presented case formulations at grand round meetings to review, receive, and give feedback of current therapeutic goals and approach of clients

Stars Behavioral Health Group

Compton, CA

September 2012—August 2013

*Doctoral Practicum Externship/Trainee*

*Setting: Community Mental Health*

- Evaluated culturally diverse children and adolescents who presented with severe symptoms of diagnoses including Conduct Disorder, Post-Traumatic Stress Disorder, and Psychosis
- Administered, scored, and interpreted batteries of cognitive and personality assessments to youth exhibiting severe behavioral symptoms such as violent outbursts, self-injurious behaviors, and drug use
- Integrated findings from measures to yield appropriate diagnoses and recommendations in professional psychological reports
- Offered feedback of testing results, treatment goals, and progress to clients and their treatment teams
- Conducted in-home individual therapy to caregivers to provide support and skills to improve relationships with their child receiving services in the Wraparound Program
- Offered psychoeducation on CBT-based conceptualization and interventions to staff in numerous presentations
- Coordinated communication with multidisciplinary team of social workers, family therapists, parent liaisons, and therapists.
- Conducted intake interviews, formulated treatment plans, and conducted in-home and in-hospital case management to children and families to improve adjustment
- Attended multiple in-service trainings in multicultural psychology, attachment theory, and DBT skills training

Pepperdine Community Counseling Center

Los Angeles, CA

September 2012—September 2013

*Doctoral Practicum Externship/Trainee*

*Setting: Community Mental Health*

- Provided individual and couples therapy to clients diagnosed with variety of disorders including Major Depressive Disorder, Generalized Anxiety Disorder, and Post-Traumatic Stress Disorder
- Administered and interpreted outcome measures and measures of the therapeutic alliance
- Conducted phone intakes and referred clients to appropriate resources based on individual needs
- Maintained progress notes for all clients to ensure proper documentation of session content and interventions
- Served as occasional on-call therapist by carrying emergency pager that clients could contact for non-immediate life threatening crisis situations

Wiseburn School District

Hawthorne, CA

September 2011–June 2012

*Doctoral Practicum Externship/Trainee*

*Setting: School-Based*

- Conducted individual and group therapy with children ages 6-12
- Incorporated activities such as art and play therapy in order to increase verbalization of emotions and socialization skills

- Conducted phone intakes and referred clients to appropriate resources to address needs
- Maintained thorough progress notes for all clients to ensure proper documentation of session content and interventions
- Collaborated with teachers and parents to promote consistency between classroom and home settings and provided comprehensive treatment to children

**Other Relevant Experience**

Didi Hirsch Mental Health Services

Los Angeles, CA

January 2011–January 2012

*Suicide Crisis Line Bilingual Counselor*

- Completed 60 hours of intensive training on properly responding to crisis calls
- Screened incoming calls and assessed for lethality of English and Spanish Crisis Lines
- Developed rapport and created individualized safety plans for callers with suicidal ideation and/or intent
- Member of specialized team that monitored high risk callers by offering additional support and resources
- Assisted in training new volunteer counselors by conducting role-plays and providing feedback

Maryvale School

San Gabriel, CA

May 2011–August 2011

*Behavior Assessment Consultant*

- Conducted class observations of children with developmental disorders to assess student-teacher interactions
- Designed psychoeducation presentations about Autism Spectrum Disorder (ASD) for professionals in education
- Trained teachers in learning appropriate intervention strategies for students with ASD in a general-education classroom setting

Intercare Therapy, Inc.

Los Angeles

December 2008–September 2010

*ABA and DIR Floortime Therapist*

- Promoted emotional-developmental milestones using relationship and play-based interventions, including Applied Behavioral Analysis (ABA) Therapy and the Developmental, Individual-Differences, and Relationship-based (DIR) model, for children with Autism Spectrum Disorder (ASD)
- Provided customized services and goals as stated in each client's Individualized Educational Plan (IEP)
- Wrote accurate reports demonstrating applied knowledge of goals, interventions and progress
- Input daily updates in Welligent and Non-Public -School Agencies (NPA) computer programs

- Created and implemented reinforcement techniques that are now standard at client's school

East Los Angeles Community Youth Center

Los Angeles, CA

November 2010–June 2011

*Interim Executive Director & Mentor Coordinator*

- Implemented technology assisted curriculum to decrease dropout and crime prevention for local youth
- Conducted outreach presentations to schools, social and juvenile services, youth detention facilities, recreation centers and other youth serving organizations to establish formal partnerships
- Assessed and tracked behavioral and attitudinal changes of mentees
- Managed organization's resources within budget guidelines
- Identified resource requirements, research funding sources, establish strategies to approach funders, submit grant proposals, and administrate fundraising records and documentation

Research Experience

Pepperdine University, Graduate School of Education and Psychology

Los Angeles, CA

September 2013–September 2016

*Doctoral Dissertation*

*Title: "Providing Hope: A Systematic Development of a Resource Development for Mental Health Professional Treating Latino/a Adolescents"*

- Conduct a comprehensive and interdisciplinary review of literature related to exploring risk factors for suicide within adolescent Latino/a populations and available evidence-based interventions.
- Integrate literature to systematically develop a resource manual to promote appropriate adaption of suicide interventions to meet cultural needs of suicidal Latino/a adolescents in treatment

Children's Hospital Los Angeles—Teen Impact

Los Angeles

September 2013—August 2014

*Research Assistant*

- Recruit participation of inpatient adolescents in the Bone Marrow Transplant Unit into an in-person support group via tablet computer technology
- Administer and collect service-review surveys and semi-structured interviews to inpatient and in-person participants
- Transcribe recorded interviews and input data entry of surveys
- Co-auditor of inductive content analysis to monitor inter-coder agreement amongst and ensure the validity and credibility of the qualitative study
- Co-Author of methodology, results, and discussion section of study's research to be submitted for publication



UCLA Health & Services Research Center

Los Angeles, CA

May 2008–November 2008

*Research Intern*

- Performed extensive research on cross-cultural adoption by collecting relevant data and journal
- Translated and edited Cognitive Behavior or Therapy based manuals to treat bilingual (Spanish) patients with depression and diabetes
- Prepared and organized data through confidential Endnote bibliography libraries and Excel data sheets
- Maintained frequent communication with research team for data updates

**Assessment Training**

Adaptive and Personality Assessment

- MMPI-2; MMPI-A; BASC-2; BASC-3; ABAS-II; MCMI-III; MACI; M-PACI; Rorschach; TAT; RISB; H-T-P; TEMAS; TSCC; TSCYC; Roberts-2; Conners-3; SASSI-2; SASII; SASSI-A2; TOMM; OQ-45.2; Y-OQ; PSQ; Achenbach CBCL; BDI-II; ASRS; ECBI; PCRI; PSI-3; RCMAS 2;
- Test administration, interpretation, and report writing

Cognitive, Achievement, and Neuropsychological Assessment

- WISC-IV; WISC-V; WAIS-IV; WPPSI-IV; WIAT-III; WF-Academic Skills; WJ-III; WASI-II; TONI-4; MMSE; WRAT-4; VMI-6; Bender-II; RAVLT; TRAILS; COWAT; CPT-II; K-BIT; COGNISTAT; TOMAL-2
- Test administration, interpretation, and report writing

Language Assessment

- EOWPVT: Spanish Bilingual; ROWPVT-Spanish Bilingual; PLS-5 (Spanish and English); Woodcock-Munoz Language Survey-R, English/Spanish
- Test administration, interpretation, and report writing

**Certifications**

- Leadership Education in Neurodevelopmental Disabilities (CA-LEND), MAY 2016
- The Incredible Years: Child Group Leader Training, November 2015
- The Incredible Years: Parent Group Leader Training, July 2015
- Trauma-Focused Cognitive Behavioral Therapy, January 2013
- Applied Suicide Intervention Skills Training, January 2010
- Nonviolent Crisis Prevention Intervention Training, September 2008

**Language Skills**

Fluent in Spanish

- Conduct therapy and intake interviews for Spanish-speaking clients and/or their families
- Translate clinical letters, documents, and assessment recommendations for Spanish-speaking families

- Administer bilingual assessments and provide feedback sessions to Spanish-speaking families

**Teaching Experience**

Pepperdine University

Los Angeles, CA

December 2013—April 2014

*Teaching Assistant*

*Course: Professional Roles, doctoral level*

- Assisted the professor in the management of course materials
- Organized and planned paperwork and dates for invited presenters of the course
- Conducted and provided literature on research relevant to the course discussion

**Presentations**

- Bellete, N. & Gutierrez, R. (2013, March). Systematic Sexual Violence Occurring in Wartime and Under Civilian Rule. Symposium at the Association for Women in Psychology Conference.
- Gutierrez, R. & Rivero, R. (2012, October). Examining Suicidality Among Latino Adolescents and Young Adults: Implications for Cultural Diversity in Treatment. Poster Presentation at the National Latino/a Psychology Association Conference.
- Peña, C., Gutierrez, R., & Harrell, S. (2012, May). Empirical Psychological Research and Anthropological Ethnography: Allies in the Promotion of Well-Being Among Ethnocultural Minorities. Poster Presentation at the Society for the Psychological Study of Ethnic Minority Issues (APA Division 45) Conference.

**Conferences and Workshops Attended**

- Society for Humanistic Psychology (Division 32), March 2013
- Association for Women in Psychology Conference, March 2013
- National Latino/a Psychology Association Conference, October 2012
- American Psychological Association Convention, August 2012
- Society for the Psychological Study of Ethnic Minority Issues (APA Division 45 Conference), May 2012
- Multicultural Research and Training Lab Biennial Conference, October 2012

**Professional Affiliations**

- American Psychological Association, Division 35, August 2012-Present
- Psi Chi: National Honor Society in Psychology, June 2008–Present

**Honors and Awards**

- Marco Garcia Memorial Fellowship, January 2012

**Community Service**

The Epilepsy Foundation of Southern California

Los Angeles, CA

January 1999–August 2010

*Committee Member—Teen and Family Retreats*

- Successful in raising \$25,000 for summer retreat program
- Designed and facilitated programs for persons diagnosed with Epilepsy and other comorbid disorders
- Tended to children with special needs including Mental Retardation, Cerebral Palsy, and Autism
- Received First Aid and CPR training, with emphasis towards emergency responses to seizures

Hermanas Unidas, Inc. de UCSB

Santa Barbara, CA

September 2004–June 2005

*Academic Advisor*

- Provided resources and opportunities to ensure academic success for members
- Maintained lasting communication and networking between members, sponsors, and supporters
- Conducted presentations providing information to enhance members' academic experience: Resume Writing, Graduate School workshops, and Scholarship opportunities
- Planned events for local community service event including Mentor Program
- Coordinated campus events involving diversity and cultural awareness, alternative activities, and fundraising

## ABSTRACT

This resource guide was developed to further cultural competency for mental health clinicians working with suicidal Latino/a adolescents (ages 10-18) based on a comprehensive review of the literature. The development of the resource consisted of three main steps: 1. Reviewing the literature to determine risk and protective factors of suicide for Latino/a youth; 2. Reviewing literature to determine common themes of Evidence-Based Practices focused on addressing suicide for adolescents; and 3. Integrating the literature from both topics to inform the contents of the manual. The resource guide provides the results in a brief, user-friendly format for clinicians to use as an adjunct for treatment for suicidal behaviors in Latino/a youth. The manual also includes six exercises that were developed based on results from the literature review, including family-focused sessions. Recommendations for further study include evaluation from field experts and training workshops to receive feedback to support its efficacy in therapy and modify as needed.

## **Chapter I: Introduction**

Suicide in the United States is a topic that can impact a person at any point throughout their life. Overall, suicide is ranked the tenth leading cause of death in the United States. For adolescents, the ranking of suicide is significantly higher than the general population; suicide is the third leading cause for children ages 10-14 and the second leading cause for ages 15-24 (Center for Disease Control [CDC] WISQARS, 2015). The Center for Disease Control and Prevention also revealed that each year in the United States, approximately 2,000 to 2,500 adolescents under the age of 20 complete suicide. Moreover, it is reported that 100-200 suicide attempts are made for every one completed suicide amongst this age group (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Adolescents remain at very high risk for suicide through a large portion of their young lives. The urgency in finding resolutions to reduce these numbers is clear; however, the difficulty in addressing this issue is in identifying the complex reasons adolescents are so susceptible to suicide. The current research exploring adolescent suicide is making great contributions into answering this question, but given the increase of attempts and completed suicides over the recent years, there is still a lot of catching up that needs to be done.

As one delves further into understanding this issue, especially when incorporating how cultural factors affect the risk of suicide for adolescents, even more alarming statistics arise. Research shows that Latino/a youth are at an even greater risk for suicidal behavior than any other ethnic group (Canino & Roberts, 2001). According to Smokowski, Ferdon, and Stroupe (2009), “Significantly more Hispanic youth (12.8%) reported making a suicide plan in the past year than either non-Hispanic, White (10.8%) or non-Hispanic, Black (9.5%) students” (p. 243). In addition, the authors found that reports of suicide attempts in Latino/a youths (10.2%) were significantly higher than non-Hispanic White (5.6%) and Black (7.7%) students. When placing

these numbers into context of the U.S. population, Latino/a adolescents account for 41.1% of the youth in this nation and represent 30% of the entire Latino/a population. As the Latino/a population in the United States continues to rise, so does the need to address suicidality among its most susceptible minority group. Acknowledging the urgent need is the first step in promoting change. It is, therefore, the ethical and professional responsibility of mental health providers to evaluate the cultural factors and needs when developing interventions to initiate the most effective change. As such, exploration of what makes this particular subgroup of adolescents especially vulnerable to suicidal behaviors will be explored in this dissertation.

Evidence-based programs are a current major appeal in psychology because they objectively demonstrate significant outcomes for their participants and set standards of care (Kazdin, 2008; Nation, Crusto, Wandersman, Kumpfer, & Kaner, 2003). In general, therapy programs for suicide intervention are designed to provide support at the penultimate stage before suicide, at a time when the suicidal person is most vulnerable (Shaffer & Craft, 2000). Most programs are based on evidence-based practices supported by rigorous research methodology. These research results translate to health policies, therapeutic interventions, theories, and training programs for treating suicidal patients. Given the potential lethality that is involved with suicidal clients, it is absolutely imperative that interventions are indeed proven to be effective in reducing the lethality of a suicidal client.

The efficacy of an empirically supported intervention for suicide can potentially change when implementing them with clients with different cultural experiences. One must remember that the ultimate goal in studies of evidence-based practices is to demonstrate their reliability and generalizability with a variety of clients. Unfortunately, most studies with significant positive effectiveness of these practices cannot replicate the same results when a component of the study

is different than the original study. Staying true to the original program design, otherwise known as *program fidelity* (Nation et al., 2003), therefore becomes a challenge when attempting to administer it to a population different than the original study. This is not to say that existing evidence-based practices for suicidal adolescents cannot be effective for the targeted population of this dissertation, specifically; it can, however, greatly reduce the true efficacy of the intervention as it is not adapted to meet the needs of the targeted demographic. This gap between research and practice remains to be a large challenge in mental health. The U.S. Department of Health and Human Services (2001) found that in all clinical trials that reported data on ethnicity, very few minorities were included and not a single study analyzed the efficacy of the treatment by ethnicity or race.

In the case of suicide intervention for Latino/a adolescents, despite the acknowledgement that there is an urgent need for this population, there is a paucity of resources and effective culturally sensitive interventions for them. To date, no published studies discuss an evidence-based treatment developed specifically for risk factors in Latinos/as dealing with suicidal thoughts and intent. As a result, while interventions developed from research are valuable as they are, there is still a crucial need to expand and improve their efficacies by integrating it into more culturally adapted methods that can better meet the needs of individual clients. This dissertation aims to start the process of closing the gap between empirically based interventions for adolescent suicide in general and the risk factors associated with Latino/a adolescents, specifically by developing a resource manual that incorporates these two topics. By examining the documented interventions and treatment outcomes for adolescents, modification of these intervention strategies so they can more effectively treat a targeted culture-specific group (e.g. the Latino/a community) becomes clearer.

Given that this dissertation highlights on culturally adapting practices, something that is limited in the research, the discussion of how beneficial it is to culturally tailor any EBP. Despite this limitation, “significant gains have been made in recent years, with many treatments [as they are] classified as probably efficacious or possibly efficacious for ethnic minority youth” (Huey & Polo, 2008, p. 2). Much of the literature does show that ethnic minorities, including Latinos/as can benefit from a well-supported EBP (Huey & Polo, 2008). Some researchers highlight that when these EBP’s it further improves the efficacy for the targeted minority group and increases the EBP’s “*ethnic invariance*” (using the EBP with other groups while still maintaining it’s level of efficacy; Huey & Polo, 2008). Other researchers, however, highlight the, the potential limitation of these poorly supported culturally-adapted treatments, and even potential harm this can present. In fact, there is little evidence to support any difference between using an EBP as or a culturally-responsive version of that treatment (Sue, Zane, Hall, & Berger, 2009). They stressed that overemphasizing the use of “conceptually appealing but untested cultural modifications” could minimize the efficacy and benefits of the original EBP for this population and thus further reduce quality of treatment for minority clients (Sue et al., 2009). The risk of this occurring increases as pieces of the EBP is replaced or minimized by various cultural components that may or many not be relevant. This is an important discussion that continues to occur within the psychology field that will continue to be had; for this dissertation, however, it is important to keep in mind that while increasing and improving cultural competency is ethically important, finding the balance between incorporating those skills with the beneficial aspects of the actual treatment is important to consider.

Sue and colleagues provided a couple of suggestions to avoid this and is recommended it be considered throughout this dissertation (2008). The first is to encourage mental health



practitioners to identify EBP's that have shown some promise or potential of helping Latino/a youth (i.e. CBT, IPT, etc.). Once those have been identified, the clinician must recognize and be aware of how cultural factors may relate to the individual in addition to other factors that are impacting their mental well-being. "Race does not provide an adequate explanation of the human condition" (Sue et al., 2009); the clinician must, therefore, use caution when using any culturally-adapted tool as it should not be used to replace the other essential pieces that complete the conceptualization of an individual.

### **Definition of Terms**

To facilitate the discussion of culturally tailored interventions for suicidal Latino/a adolescents, definitions of commonly used terminology are provided. These terms are found throughout the psychological literature; however, many authors vary or vaguely describe the meaning of the terms used and can cause confusion. For the purposes of this dissertation, the definition following each term will be used:

**Adolescence.** When reviewing literature on adolescent development, the definition of the term "adolescence" varies so greatly that it becomes difficult to have a clear idea of what it actually is. Some authors define it quantitatively (i.e. a specific age group), such as between puberty and 18 (Kaplan, 2004), which is the more commonly accepted range; and others base it more qualitatively, or what is experienced during this time. For example, Waddell (2002) defined adolescence as "a process of adaptation to the physical and emotional changes of puberty and this adjustment entails finding a *new sense of oneself-in-the-world*, a discovery of who one is, which involves the capacity to manage separation, loss, choice, independence and disillusionment with life on the outside" (p. 2) Other studies do not provide a clear definition of adolescence, and thus, leave it to the reader to assume what population exactly they are referring

to. It then becomes difficult to figure out the author's own interpretation of adolescence and that a universal consensus on its definition is not immediately clear.

In recent years, there is an emerging contemporary view of adolescence that is being more commonly accepted by researchers of child and adolescent development. Arnett (2010) combines historical, theoretical, and contemporary research to define adolescence specifically as the period spanning from ages 10-18. His reasoning is that adolescents in the United States are typically still very dependent on their caregivers and experience what G. Stanley Hall described as heightened *storm and stress* in this specific age group. Arnett's (2010) modernized description of *storm and stress* is a period in adolescence that is more difficult in some ways than other periods of life. There are 3 key aspects with this idea including conflict with parents, mood disruptions, and risk behavior. Arnett goes on to say that following the age of 18, these experiences are no longer normative since many individuals have a better sense of self-definition and start learning how to be independent, a stage he terms *emerging adulthood*. Given that the adolescence age span falls within the range where suicide is at its highest risk, Arnett's definition of adolescence is most appropriate for the purposes of this dissertation. As previously stated, however, studies focusing on adolescent development vary in their definition of adolescents from being very specific to not providing a definition at all.

Given the cultural focus of this dissertation, it cannot go without considering the issues of diversity within this particular definition of adolescence. At best, the term *adolescence* describes vast inter- and intra-variability experienced uniquely across cultures, historical times, and individuals (Kaplan, 2004). As such, Arnett noted that his definition of adolescence, storm and stress, and emerging adulthood predominantly stem from an individualistic perspective of a Western society, namely the United States. Some cultures, mostly non-Western, however, have a

more collectivistic stance and the concept of storm and stress in adolescence is less relevant. It becomes more relevant, however, when part of the adolescent's experience involves assimilation from their original culture to the new culture with Western views. This is especially true for the Latino/a community. The culture within adolescence and how it effects the risk of suicide among this population will be explored in greater detail in the literature review; it is important, however, to first acknowledge that while adolescence does involve a defined age group, the cross cultural experience of adolescents is also essential to consider.

To summarize, for the purposes of this dissertation, Arnett's clear definition of the age group between 10 and 18 years of age as adolescence will be used. As interventions and cultural considerations are discussed, it should be noted that this definition still comes from an individualistic view and can be perceived differently when working with cultures from a more collective family-focused perspective, including the Latino/a culture. As such, it is important to consider how these cultural aspects can influence how adolescence between this ages group is perceived to them and their families.

### **Suicidality**

Similar to defining "adolescence," what is often missing throughout the literature researching "suicidality" is a clear consensus of its definition. Research on suicide tends to tailor the definition of suicide to fit the specific needs of their study. This can include an aspect of suicidality, such as suicide attempts, or can include a lump of characteristics including ideation and self-injurious behaviors. Some researchers, however, do not provide a definition of suicidality in their literature review, thus adding to the confusion of what is truly meant when an author uses this term. Meyers and Straub (2010) noted this ambiguity and made suggestions on how to address this concern after hosting a consensus conference for members of academia and

government. The authors determined that due to the vague and varying interpretation of suicidality, objective terms, such as suicidal ideation, suicidal behavior, and suicide should be used instead. Operational definitions of these terms should then be disseminated across all cultures and languages. Based on this result, for this dissertation suicidality will strictly be used to include these new objective terms. More specifically, suicidality in this dissertation will be behaviors including suicide attempts, planning, gaining access to means, and suicidal ideation (including passive and active).

Some studies regarding suicidality include non-suicidal self-injurious behaviors (NSSIB), such as cutting to cope with an intense emotion, as a behavior of suicide. While NSSIB can be a risk factor for suicide, there is no clear intention to end one's life with this specific behavior. As such, literature including NSSIB will be reviewed, however, studies discussing purely NSSIB's will not be included.

### **Latino/a**

The use of *Latino/a* is vaguely defined in most studies researching this population. Representations of U.S. Latinos/as are commonly generalized in popular media and scholarly articles with terms that attempt to encompass the diversity of cultures and races into the one group called Hispanic or Latino/a (Rojas, 2013). This becomes problematic in the sense that unique diversity of the individual becomes overshadowed into more generic stereotypes that includes "typical" values and perspectives. While contemporary researchers attempt to delineate within-group differences of Latinos/as, a critical review of this literature is beyond the scope of this dissertation's goal. Instead, a brief overview of the current understandings of the pan-ethnic term Latino/a will be provided here.

Generally, most people have some understanding of what it means to be Latino/a or Hispanic. The U.S. 2010 Census defines it as “a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race” (para. 1). It adds that Hispanic origin “can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person’s parents or ancestors before their arrival to the United States” (para. 1). This is a helpful and an overall clear definition that provides a good broad picture of what it means to be Latino/a, or Hispanic. However, a closer look at this definition shows this includes a large variety of diverse individuals who can easily fall into this very broad category. In turn, the diversity of these individuals becomes overshadowed in a larger generalized category. Due to the wide diversity of cultures that fall under the large category of Latino/a or Hispanic, the interpretation and definition of these terms can change from person to person. As such, many of these individuals use more specific descriptors other than Latino/a, such as Chicano or Cuban-American.

Latino/a is also frequently not clearly defined in the literature, which supports the idea that there is a general assumption throughout U.S. society that a person identifying as Latino/a falls within a category of specific characteristics. In the existing literature within the field of psychology, the definition of Latino/a or Hispanic evolved over time as described by Padilla (2002). Padilla (2002) describes that the term Hispanic was first used in Mental Health Literature in the 1970s. Since then, due to the increasing awareness of the importance of an ethnic label an individual uses to self-identify, the term Latino/a began to be more frequently used in the literature (Padilla, 2002). The problem arises when multiple authors and contributors to the field began using the various descriptions to fit their own individual perspective of what it means to be a Latino/a or Hispanic and assumed others would follow.

To complicate matters even further, much of the literature uses the term Hispanic and Latino/a interchangeably, even though these two terms have different meanings. To many, being Hispanic “means claiming allegiance to European ancestry, particularly Spain (with its language and Catholic heritage); however, to be Latino/a there is an identity with indigenous ancestry that is separate from Spain” (Rojas, 2013, p. 375). Romero (2005) addresses the problems that arise when equating Hispanic with Latino/a:

The reduction of Mexicans, Chicanos, Puerto Ricans, Cubans, Salvadorans, Nicaraguans, Costa Ricans, and other groups to the single category of ‘Hispanic’ has been met with resistance. There are two main objections: one is the depoliticization of each group’s distinct history with the U.S. (colonized, conquered, exploited, etc.); the other is the emphasis upon Hispanic (European) culture and ancestry, rather than African and indigenous cultures (p. 28).

This distinction between Hispanic and Latino/a, however, is rarely made in research studying these communities. Moreover, there may not be one formula to resolve this broad definition of a Latino/a individual, but it would be negligent if this dissertation did not attempt to create a definition that would best acknowledge these diversities. The literature that does define Latino/a still does not distinguish between the many national-origin groups included under the broad Latino/a umbrella. For example, most studies typically focus on individuals from countries in North, Central, and South America. More rarely stated are the regions in the U.S. where these participants are from, acculturation, or assimilation issues, unless the study is specifically researching these topics. This eliminates the diversity of various experiences; for example, what a Mexican American immigrant in Southern California experiences is likely different from that of a Puerto Rican migrant in New York. Therefore, Latino/a as a category is best seen as pan-

ethnic and certainly very heterogeneous, in the sense that it encompasses a range of cultures, racial backgrounds, national origins, and other important dimensions of diversity (Delgado & Stefancic, 2001). For the purposes of this study, the definition from the U.S. Census, along with this view of the term Latino/a, will be used throughout this dissertation, as it best acknowledges the diversity within this category while still acknowledging a group of people in great need of cultural-specific care. Moreover, the “/a” added at the end of “Latino” is a description that has gained much popularity in Latin American studies. It is a result of Latina feminist movements that began in the 1970s to acknowledge women of Latino/a heritage. It will, therefore, also be used in this dissertation to further encourage gender diversity among this community.

### **Evidence-Based Practice**

Based on the American Psychological Association (APA) Presidential Task Force (2006), Evidence-Based Practice in Psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. The purpose of EBPP is to promote effective mental health practices and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention (APA, 2006). For suicide prevention, positive outcomes are reductions in suicidal behaviors or changes in suicide-related risk and/or an increase in protective factors. Cognitive Behavior Therapy (CBT) most commonly falls under this category since its objective and structured approach makes it attractive for researchers trying to gain an objective and clear result. Nevertheless, this dissertation will continue to use the 2006 definition of EBPP, which allows for a variety of culturally congruent approaches to suicide prevention and treatment.

The preceding elaboration of the terms adolescence, suicidality, Latino/a, and EBPP provides context and clarifies how they will be used throughout the dissertation. Distinctions that differ from the definitions provided will be elaborated throughout the literature review to ensure there is a clear understanding of how these terms are being used by the author.



## **Chapter II: Review of the Literature**

This chapter provides a summary of the current literature as a means to provide background information and justification for this study. First, there will be an overview of previous research that explores the suicidal risk factors of Latino/a youth. The focus will be primarily on areas that are specific to the Latino/a community that are unique from risk factors for adolescents in general. There will then be a discussion of research that has explored the effectiveness of suicide intervention and prevention on adolescents, and treatments with empirical evidence for this age group. It is important to note that the review of the literature in this chapter is not comprehensive in that it addresses all risk factors and interventions. Factors that are included were done to highlight and support the need for a manual that guides clinicians in how to better adjust interventions to meet the cultural-specific risk factors of the adolescent they are treating. Finally, the chapter will combine these two areas to provide a statement of rationale for this study.

### **Risk Factors for Suicidal Latino/a Adolescents**

As previously stated, there is an overwhelming amount of evidence that demonstrates the need for more research and intervention strategies for this population. There are multiple ways to approach this, but before developing a culturally adapted intervention strategy for Latino/a adolescents, one must first determine factors that increase the risk of suicidality among Latino/a adolescents. Similarly, these risk factors also play significant roles as barriers to this population receiving access to mental health care services. The most common factors are discussed in greater detail below.

**Adolescent culture.** One risk factor for Latino/a adolescence is the mere fact that they are adolescents. As discussed earlier, teenagers in the United States make more suicide attempts

than any other time in life. However, given that a large number of adolescent suicides are first-time attempts, understanding the circumstances that precede suicide attempts—including the nature of suicidal ideation and of the cognitive and emotional responses that precede ideation—is a critical part of preventing a potentially lethal attempt (Miranda & Shaffer, 2013). Population-based studies of adolescents suggest that the transition from suicidal ideation to attempt occurs within approximately one year of onset of the initial suicidal ideation. This section, therefore, examines some of the potential psychological precipitants that may inform how suicidal thoughts are transferred into action.

Based on numerous studies, adolescents at higher risk commonly have a history of depression, a previous suicide attempt, a family history of psychiatric disorders (especially depression and suicidal behavior), family disruption, and certain chronic or debilitating physical disorders or psychiatric illness (Gould, Greenberg, Velting, & Shaffer, 2003). Living out of the home (in a correctional facility or group home) and a history of physical or sexual abuse are additional factors more commonly found in adolescents who exhibit suicidal behavior (Hodgman & McAnarney, 1992). Psychosocial problems and stresses, such as conflicts with parents, breakup of a relationship, school difficulties or failure, bullying, body image issues, legal difficulties, social isolation, and physical ailments are also commonly reported in young people who attempt suicide. Moreover, gay and bisexual adolescents have been reported to exhibit high rates of depression and are three times more likely than other adolescents to attempt suicide. Additionally, long-term high levels of community violence may contribute to emotional and conduct problems and add to the risk of suicide for exposed youth (Cooley-Quille, Turner, & Bidel, 1995). Finally, gender also appears to be a risk factor upon evaluation of statistics, which shows that boys between ages 13 and 19 are more likely to die by suicide than girls (Miranda &

Shaffer, 2013). One hypothesis for this is that boys tend to use more lethal means during an attempt than girls. It can easily be seen by this list of contributing factors that there are many aspects of an adolescent's life that need to be assessed when determining his/her level of risk for suicidal ideation and attempt. While it is easier to evaluate each of these factors in their own unique way, the reality is that many adolescents face many of these factors concurrently, increasing the complexity of determining what exactly leads an adolescent to actually attempt.

Further examination of psychiatric histories as a risk factor for suicide in adolescents shows that depression places the highest risk. Depression in childhood is about 1.1 % (McGee, 1983), but there is a significant increase in adolescence, estimated at 4.0 % to 20% (Whitaker, 1990). This makes it important to explore how strong an adolescent's skill in emotional regulation is when defending against symptoms of depression, including suicidal ideations. Emotion regulation is often described as those skills, behaviors and strategies that may initiate, control, modulate, inhibit or enhance emotional experiences and expressions in order to adapt to a specific situation (Gross & Munoz, 1995). In other words, it is defined as the level of an individual's ability to manage his or her emotions in response to various life stressors. Adolescents with a secure attachment style appear to be able to regulate high emotional states by using functional regulation strategies (Sroufe, Egeland, Carlson, & Collins, 2005). Conversely, adolescents who report an insecure attachment have significantly weaker skills in emotion regulation, which leads to less support seeking behaviors and greater depressive symptoms (Shirk, Gudmundsen, & Burwell, 2005).

When evaluating multiple factors that adolescents face during this period, a strong focus should be placed on the individual's social interactions. According to Weiss (1982), attachment behavior in adolescence is often directed towards peers. Because of growing conflicts with

parents, adolescents may switch to peers as their primary attachment figures (Holmbeck & Hill, 1991). This is especially crucial information when determining how suicide in particular influences suicidal behaviors in adolescents. Shaffer and Craft (2000) found that adolescents who know about one suicide may facilitate suicidal behavior in others as a function of contagion or imitation. Additionally, evidence shows that this can manifest in many ways, such as “suicide epidemics or clusters, or as an after effect of new or fictional coverage of suicide” (Shaffer & Craft, 2000, p. 72). Adolescents’ increased exposure to suicide through a multitude of sources, including media, can significantly affect an adolescent’s decision to transition their suicidal ideations to an attempt.

Substance abuse is another important risk factor associated with suicide. Studies have consistently demonstrated that suicidal behaviors are more likely to occur among adolescents who abuse alcohol or use illicit drugs (Shaffer & Pfeffer, 2001). Abuse of these substances have been shown to increase the inclination for suicidal behaviors by affecting emotional and cognitive development, and long-term use can permanently affect an individual’s judgment.

As demonstrated, it is clear that there are a number of vulnerabilities adolescents are exposed to that places them at risk for dangerous, and more specifically, suicidal behaviors. Despite the extensive research that exists describing these vulnerabilities among adolescents in general, it still does not describe the specific risk factors that are unique to Latino/a adolescents. These are described below.

**Cultural stigma and fear.** The literature highlights stigma and fear as a cultural-specific factor that impacts the risk of suicidal behaviors among the Latino/a community. In other words, the stigma and fear of suicide and mental health can influence an adolescent’s decision to seek help. Goldston et al. (2008) explored cultural factors that affect the help-seeking behaviors of

Latino/a adolescents at various stages. The first stage is identified as recognizing the problem, which can be perceived, labeled, or tolerated differently in different cultural groups (Cauce et al., 2002). If an adolescent acknowledges the problem and chooses to seek help, the cultural stigma of suicide and mental health within the Latino/a community can prevent the next stage of seeking professional mental health intervention. For example, researchers found that some newly immigrated families who are unfamiliar with the service system in the United States are often apprehensive of it because they fear being reported as undocumented (Berk, Schur, Chavez, & Frankel, 2000). Additionally, other factors include negative prior experiences with service procedures and resources, such as not understanding and lack of explanation of emergency room procedures, confidentiality and HIPAA rights, and hearing stories of “bad therapists” (Rotheram-Borus et al., 1996). Given these potential factors, many adolescents believe that problems such as suicidal behaviors should only be dealt with by the family or faith community rather than specialty mental health services (Cauce et al. 2002). These help-seeking behaviors of Latino/a adolescents highlights the need for culturally-tailored interventions to consider and address what is the most appropriate response to a crisis that matches their cultural values and family-centered ideals.

**Limited access to care.** Disparities in access to mental health care based on race and/or ethnicity, income, gender, age, geography, and sexual orientation are well documented and continue to be a problem. More specifically, much evidence shows racial and ethnic minorities in the United States are less likely than Whites to seek mental health treatment, which largely accounts for their underrepresentation in most mental health services (U.S. Center for Mental Health Services [CMHS], 2001). Further, Latinos/as in need of mental health care are less likely

than non-Latino/a Whites to access mental health services, and when they do receive care, it is more likely to be poor in quality (U.S. CMHS, 2001).

Language barriers partly account for these disparities in mental health access and treatment quality. A lack of sufficient bilingual and bicultural mental health professionals often results in miscommunication and misinterpretations. This becomes especially important when there is an attempt to incorporate the support of parents of adolescents, who are more likely to be monolingual Spanish-speakers. Most suicidal Latino/a youths are U.S. born English speakers, which makes communication about suicide with their Spanish-speaking parents more difficult. Because youth often want parental involvement in their treatments, Spanish-speaking parents are at a disadvantage (Goldston et al., 2008) due to the insufficient number of Spanish-proficient providers. Latinos/as with limited English proficiency also frequently do not have critically important information, such as how and where to seek mental health services, which can provide an additional barrier to accessing care. Moreover, language barriers contribute to the problems Latinos face when accessing public transportation to visit mental health clinics and to the difficulties that they encounter with completing required paperwork at clinics. The lack of culturally and linguistically appropriate mental health services (e.g., in the preferred language of clients), compounded by mental health stigma, keeps many Latinos/as with mental illness from seeking services.

**Immigration, assimilation, and acculturation.** The most researched contributing risk factors of Latino/a suicide are issues of immigration, assimilation, and acculturation. To understand the strong impact of acculturation for this population, a review of the immigration history of Latinos/as in the United States is important. Many challenges arose for a large majority of migrants seeking work and trying to settle their families into an unfamiliar

environment. This increased this population's vulnerability and susceptibility to pressures to acculturate and assimilate, and additionally deal with stress from hardship and poverty that often accompany these difficult transitions. (Aguilar-Gaxiola et al. 2012). This left the immigrant generation exposed to a wider range of significant life stressors and experiences, such as poor housing and communities, discrimination, trauma, abuse, and exploitation. The first and second generations to follow also were impacted by this unique form of stress, along with trying to balance their family's culture from their country of origin with the culture of the United States.

Statistics show that a large majority of Latino children in the United States (52%) are U.S.-born with at least one foreign-born parent, whereas another 11% of Latino children are foreign-born and growing up in the United States (Fry & Passel, 2009). It is therefore important to explore the expansive research on how these factors of immigration and assimilation impact the parent-adolescent relationship and the role they play on an adolescent's emotional functioning. Although parent-adolescent conflict has largely been conceptualized as a relevant stressor across ethnic groups, the acculturation process, which is a unique stressor, has the potential to influence the content of parent-adolescent conflict. Indeed, recent studies have begun to explore a more nuanced understanding of the specific content of parent-adolescent conflict in immigrant groups and its impact on psychosocial functioning (Huq, Stein, & Gonzalez, 2015). More focused studies on acculturation gaps (i.e. a discrepancy between a parent and a child regarding their acculturation status) found that they can lead to negative outcomes in Latino/a youth, such as greater family conflict, anxiety, depression, and lower self-esteem (Martinez, 2006).

Substantial research has been conducted to explore how this form of stress contributes to suicidal risk for immigrant adolescents coping with acculturation and assimilation. Smokowski,

David-Ferdon, and Stroupe (2009) determined that a substantial group of adolescents is likely to wrestle with acculturative conflict during formative stages in their development. Furthermore, this acculturative stress among Latino/a adolescents is associated with higher levels of thoughts about suicide (Hovey & King, 1996). For adolescents who are immigrants themselves, a study by Swanson, Linksey, Quintero-Salinas, Pumariega, & Holzer, (1992) found that Mexican youth residing in the U.S. had significantly higher rates of suicidal ideation than peers living in Mexico, and that U.S. residency significantly predicted more suicidal thoughts. Other consistent findings also suggest that a traumatic immigration process to the United States can increase an adolescent's suicidal ideation.

The risk of suicide continues to grow as U.S. born adolescents with immigrant parents and/or grandparents increases. Pena, Matthieu, Zayas, Masyn, & Caine (2012) also found that immigrant generation status was a determinant for suicide attempts, problematic alcohol use, and repeated other drug use for Latino/a adolescents. A more in-depth review conducted by Bridges, de Arellano, Rheingold, Danielson, and Silcott (2010) of the results show that U.S.-born Latinos/as with immigrant parents were 2.87 times more likely to attempt suicide, 2.27 times more likely to engage in chronic alcohol use, and 2.28 times more likely to engage in chronic drug use than were foreign-born youth; additionally, later-generations of U.S.-born Latino/a youth with U.S.-born parents were 3.57 times more likely to attempt suicide, 3.34 times more likely to engage in problematic alcohol use, and 2.80 times more likely to engage in repeated other drug use than were first-generation youth.

In sum, the research on this topic is clear and consistent with the correlation between acculturative stress and suicidal risk. It highlights the importance in determining an adolescent's level of coping in managing this form of conflict when assessing for suicidality.



**Familismo.** Among the Latino/a community, family, or *familismo*, is the unique core system of values centered on the family. Familismo is characterized by (a) strong identification and attachment with nuclear and extended families, (b) strong family unity, interdependence among family members, and (c) high levels of social support (Gaines, Marelich, Bledsoe, Steers, & Al, 1997). It is recognized as one of the most distinctive cultural characteristics for Latinos/as and is prioritized in day-to-day decisions and long-term goals (Raffaelli & Ontai, 2004). For Latinos/as, the sense of family can be a family member's primary source of assistance, inspiration, and strength (Finch & Vega, 2003). As such, research on post immigration familismo identifies it as a distinctive cultural protective factor against psychological distress among Latinos/as living in the United States (Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009).

It is interesting to note that as strong of a protective factor familismo can be, there is also evidence of a strong link between parental/family variables and adolescent depression (Bernal, Cumba-Aviles & Saez-Santiago, 2006). The acculturation process and accompanying stress is posited to erode components of familismo, thereby limiting the protective nature of familismo and the resiliency it provides against health risk behaviors, including suicidality (Marsiglia, Parsai, Kulis, & Southwest Interdisciplinary Research Center, 2009). As such, the relationship between familismo and acculturation must also be explored when determining its impact on an individual's risk. For example, immigrant youths are more likely than their parents to adopt the values, beliefs, and behaviors associated with the new culture, which can increase tension between these adolescents and parents. Because familismo sees the family as a collective group as a whole, Euro-American values of autonomy and individuality create issues of intergenerational tension between parents and their children, depending on varying levels of

acculturation (Duarté-Vélez & Bernal, 2007). Such discrepancies may “increase the level of conflicts between parents and adolescents, resulting in dysfunctional outcomes such as suicide attempts and psychological maladjustment” (Zayas, Hausmann-Stabile, & Pilat, 2009, p. 342). This emphasizes the point that although these risk factors are being addressed as separate categories in this dissertation, it is essential to remember that many of these categories are closely interconnected. No one element should be solely used when considering and assessing the cultural impact of suicidal risk among adolescent Latinos/as.

### **Suicide Prevention and Interventions for Teens**

The aim of this section is to review the current literature of available evidence-based suicide interventions for adolescents in general. As previously stated, information and studies on adolescent interventions are still fairly limited. Given the urgency for tailored interventions for Latino/a adolescents and burgeoning Latino/a population in the U.S. in recent years, it would be irresponsible to further wait until the literature catches up and create further delay. There is sufficient literature to further develop effective interventions for both adolescents and Latino/a adolescents concurrently, some of which are what will be reviewed next.

**Cognitive-Behavior Therapy (CBT).** Cognitive-Behavior Therapy (CBT) is a psychotherapeutic approach that aims to improve problematic and dysfunctional emotions, behaviors and cognitions through an active, goal-oriented, time-limited, and systematic problem-solving procedure (Brown et al., 2005). Standard CBT involves patients who are being taught to identify, monitor, and ultimately challenge negative thoughts about themselves or situations and develop more adoptive and flexible thoughts (Brown et al., 2005). As an empirically supported treatment of numerous mental health illnesses, including depression, CBT has indirect suicide prevention potential, and has been altered and evaluated specifically for suicide prevention. It

has also been adopted for specific high-risk groups such as suicide attempters showing a significantly lower reattempt rates for CBT patients, who were 50% less likely to reattempt suicide than participants in the usual care group (Brown et al. 2005). The severity of self-reported depression and hopelessness was significantly lower in the CBT group than the usual care group. Therefore, CBT is an effective clinical intervention option to prevent suicide in indicated suicide patients, with research showing efficacy of the treatment in all ages.

A sample CBT-based intervention is Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP). It is a manualized cognitive behavioral treatment for adolescents who recently attempted suicide ( $\leq 90$  days). Although CBT-SP was implemented with suicide attempters, the theoretical approach and strategies may also apply to adolescents who experience episodes of acute suicide ideation (as opposed to chronic, unremitting ideation) in which precipitants can be identified. The primary goals of this intervention are to reduce suicidal risk factors, enhance coping and to prevent suicidal behavior (Stanley et al., 2009). A central focus is the identification of proximal risk factors and stressors, including emotional, cognitive, behavioral and family processes just prior to and following the adolescent's suicide attempt or suicidal crisis (Stanley et al., 2009).

**Dialectical-Behavioral Therapy (DBT).** Dialectical-Behavioral Therapy (DBT) is a cognitive behavioral treatment approach with two key characteristics: “behavioral, problem-solving focus with acceptance-based strategies; and emphasis on dialectical processes” (Linehan, 2008, p. 35). Developed by Marsha Linehan (1993), it has five components:

- (a) capability enhancement (skills training); (b) motivational enhancement (individual behavioral treatment plans); (c) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (d) structuring of the environment

(programmatic emphasis on reinforcement of adaptive behaviors); and (e) capability and motivational enhancement of therapists. (p. 36)

After numerous studies supporting its efficacy in severe psychopathologies, it was adopted for including suicidal patients, depression, and many other suicide risk factors. Research on DBT as a suicide prevention strategy has found that after a year of care, 23.1% of DBT patients reported suicide attempts, compared with 46.7% of recipients of alternative expert treatments (Linehan, 2008). Multiple evaluations confirmed that patients completing a year of DBT experienced significantly less non-suicidal self-injury than patients awaiting care or receiving alternative treatment.

An adapted DBT approach for adolescents is a program called Dialectical-Behavioral Therapy in Teens (DBT) is a form of cognitive-behavioral therapy that combines individual therapy, skills training, and telephone coaching. Studies showed that it significantly reduced behavioral incidents during admission when compared with Treatment As Usual (TAU). Both groups demonstrated highly significant reductions in parasuicidal behavior, depressive symptoms, and suicidal ideation at one year (Katz, Cox, Gunasekara, & Miller, 2004).

## **Conclusion**

To date, there has yet to be any known empirically based suicide prevention or treatment interventions developed exclusively for Latino/as (Goldston et al., 2008). However, there have been adaptations of other therapies for other disorders (e.g., depression, substance abuse) that are informative and support the potential benefits of adapting and developing culturally-tailored interventions to address the specific needs of a designated culture. For example, in recognition of the cultural value of familismo, Rossello and Bernal (2005) adapted cognitive-behavioral

therapies for depressed Puerto Rican adolescents to involve parents in therapy. This research provides hope that there can be effective methods in providing improved care to this population.

Unfortunately, the psychology literature that bridges risk factors of suicide for Latino/a adolescents and current evidence-based interventions is very limited. This dissertation is an attempt to strengthen this bridge by addressing how current interventions can be tailored to be culturally appropriate for this high-risk population. For the purpose of this dissertation, a systematic review of the literature will be the principal lens used to understand cultural risk factors that influence adolescent psychological development, specifically those of Latino/a heritage. The goal is to use this information to develop a preliminary resource manual that can be used by mental health professionals to improve the practical application of suicide interventions to Latino/a adolescents. By gaining a clearer understanding of where the literature currently stands in addressing this diversity issue in this dissertation, this resource manual can then be developed to strengthen culturally sensitive approaches. It should be noted that this resource manual is not intended to be used to replace any current forms of EBP's for suicidal ideation; rather, it is the hope that this resource can be used as an additional, supplemental tool that can further enhance and improve the effectiveness of the EBP being applied by the mental health provider. It is also important to emphasize that this resource manual is not intended for individuals who are in immediate risk, crisis, or emergency situation.

As previously stated, the aim of this dissertation is to systematically develop a resource manual that presents current evidence-based treatment modalities for suicide and cultural factors related to the risk of suicidality among Latino/a adolescents.

The objectives of this study are:

1. To conduct a comprehensive review of the literature examining risk and protective factors of suicide that apply to Latino/a adolescents.
2. To conduct a comprehensive review of the literature that describes current interventions available to treat adolescents exhibiting suicidal behaviors.
3. To develop a resource manual that integrates data from literature review for mental health providers treating Latino adolescents who endorse suicidal ideation and/or behaviors.

### **Chapter III: Methodology**

The focus of the dissertation is to develop a resource manual using a systematic approach to improve recognizing suicidal risk, increase awareness of its prevalence, and applying culturally appropriate interventions to assist mental health professionals who treat suicidal Latino/a adolescents. The central goal of this chapter is to describe the methodology performed to develop the resource manual; the overall approach was systematic in that empirical data that fit criteria was collected from current literature and integrated to create a useful resource for mental health providers. This study consisted of five phases: The first phase of this study described the targeted population for whom this resource manual will benefit. The second phase consisted of a comprehensive review of the literature about current issues that arise with suicidality among Latino/a adolescents. The third phase provided an additional review of the literature to gather information of current EBP methods for intervention, including assessment, to treat suicidal adolescents in treatment. The fourth phase integrated information collected from the literature to develop the resource manual. The fifth and final phase provided the overall conclusion of the study, including a summary and recommendations for future study.

#### **Phase I: Population of Study**

Given the goal of this study is to expand the availability of effective resources to a population that has many obstacles and limitations to accessing those resources, this resource manual is targeted for patients receiving outpatient care in community-based settings. In the majority of inpatient settings, patients are already receiving an intensive level of care and may have other high-risk concerns (e.g. psychotic episode) that concurrently need to be addressed.

It must be highlighted that this resource manual is not intended to be used for individuals who are at immediate risk or in the process of attempting suicide. Should this be the case, the

primary step should always remain emergency intervention, such as calling 911 or ensuring they seek immediate treatment at a nearby hospital. This manual is aimed to assist mental health professionals, including psychologists, therapists, and social workers, who have active clients that disclose current or recent suicidal ideation, intent, with or without a defined plan (that is not within 24 hours). Given the comprehensive approach for this manual, it provides information for mental health professionals that can assist in conceptualization and intervention with Latino/a adolescents. As always, it is up to the individual provider to use their own clinical judgment and ethical responsibility to determine the level of suicidal risk and when emergency intervention is required.

### **Phase II and III: Review of Literature**

The general topic areas that were researched in this comprehensive literature review included suicide risk and protective factors for adolescents and Latinos/as, as well as the available suicide interventions for suicidal ideations with empirically supported research of their efficacy. A review of these concepts were conducted by using journals from psychology and related fields such as social work, counseling, and couple and family therapy. Concepts examined included adolescent development, adolescent culture, suicidal risk and protective factors for adolescents, culture-specific risk and protective factors for Latino/a populations, acculturation and assimilation, suicide assessment, evidence-based practice and intervention.

**Dates of publication and databases.** The literature review only included documents published from 1980 to present. The primary reason for this criterion is simply that there is limited research conducted on the subject of suicide, let alone suicidality among the Latino/a population, before 1980. Suicide was addressed as a public health problem in the early 1980s in the United States of America by the Centre for Health Promotion and Education (CHPE) under



the Centers for Disease Control and Prevention (CDC). Since then, there has been concerted effort to advocate a public health approach to the suicide problem, which focuses on identifying suicide patterns and suicidal behavior in a group or population (Yip, 2005).

It should be noted that much of the literature regarding risk and protective factors for suicide, as well as suicidal interventions, primarily focused on information within the past 10 years. This is to ensure that the information is most relevant to current clients. Historical data and theories, however, were explored as they provide deeper context as to why current risk factors and interventions evolved into their current forms.

The review of the literature relied on these dates of publication available through the primary research tools used which included the electronic databases PsychINFO, PUBMED, PsychARTICLES, WorldCat, Research Library, and Public Health statistics by state and federal health departments including the Morbidity and Mortality Weekly Report (MMWR) by Chronic Disease Report (CDR) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The keyword searches were: suicide AND adolescents, suicide intervention AND adolescents, evidence based practice AND suicide, evidence based suicide intervention, suicide AND Latinos/as, suicide AND Hispanics, adolescent suicide AND Latino/as, suicide intervention AND Latino/a OR Hispanic/Hispanic adolescents, risk factors AND suicide AND adolescents, suicide risk factors AND Latino/a OR Hispanic/Hispanic adolescents, suicide protective factors AND adolescents, and suicide protective factors and Latino/a OR Hispanic/Hispanic adolescents. To ensure that this literature review was fully comprehensive, the term “Hispanic” was also included as a keyword given that much of the literature still uses this term in describing Latino/a populations.

**Types of documents.** Documents used included peer reviewed and/or theoretical

interpretive material. Current empirical findings, and reports by reputable national organizations (e.g. NIMH, SAMHSA, etc.) were also included when available. These documents contained the following research methods: quantitative, qualitative, meta analysis, critical reviews, and theoretical materials. It should be noted that given the expanding attention to research on suicide is still relatively recent, much of the current research available may not be conclusive or may be speculative.

#### **Phase IV: Integration of Literature to Develop Resource Manual**

Once data was gathered from this comprehensive literature review, they were integrated and critiqued and used to inform the content of the proposed resource manual. The length of the resource manual is approximately 10-15 pages and information is presented in both paragraph and bullet-point format to emphasize clarity and simplicity. The manual includes diagrams and tables related to the content to further encourage comprehension of the materials. Although the proposed manual's target audience includes masters and doctorate-level mental health professionals, the manual was written with simple wording and common terminology to expand its utility and allow for review by other possible audiences, such as parents and adolescents themselves in collaboration with their treatment provider. Some additional information in Spanish, especially related to psychoeducation about suicide, was also included for clinicians to provide to monolingual Spanish-speaking families.

The proposed manual was organized into the following sections:

Section I provides the rationale for the proposed resource manual and discusses the need for its development for mental health professionals who are treating this particular population. This section consists of epidemiological data, including statistics related to incidence and prevalence of suicidal adolescents in the Latino/a community, and definitions of common terms.

This section also clarifies who is to use the manual and determine what patients this manual can be applied to. Some of the information is also helpful for parents and clients to also learn as part of the psychoeducation piece of therapy; therefore, some of these statistics are also provided in Spanish for families to also learn more about suicide, mental health treatment, and how to appropriately respond. The definition of terms Latino/a, Suicide, and Adolescence are also provided to provide clarity.

Section II outlines more detailed psychosocial factors associated with suicidal risk within Latino/a adolescent populations. More specifically, this section presents data from the literature about the risk factors and identifying individuals who are at high-risk for having suicidal thoughts and/or intent. This also includes protective factors that are unique and/or can overlap with some of the stated risk factors that are important to consider when assessing and determining appropriate treatment interventions. Common obstacles or barriers when treating suicidal Latino/a adolescents are also discussed.

Section III lists and describes the different phases of evidence-based interventions and the cultural factors to consider and/or include to increase the effectiveness of interventions at each stage. These stages include: 1. Assessment of Suicidality 2. Safety Planning and Treatment, and 3. Follow-Up and Reassessment of Risk. Six detailed exercises or activities are provided based on the integration of the literature, including strength-based approaches, that clinicians can apply in therapy. It also includes contact information for various local and national resources, such as the Suicide Hotline and Spanish resources they can provide to clients and their families.

### **Phase V: Conclusion**

This dissertation includes a final section summarizing the synthesis and critical analysis of the comprehensive literature review, and discusses the utility of the resource manual. This

section also discusses the limitations of the study, including a need for an assessment plan to evaluate the manual with current professionals. An overview of this assessment plan will be described to facilitate further study and modifications of the manual.

### **Chapter IV: Manual Development**

This chapter contains phases II, III, and IV of the project as described in the Methodology chapter. More specifically, Phase II will present the comprehensive review of the current research literature to reflect common risk factors for Latino/a adolescents for suicidal behaviors, including a history of ideation, plan, intent, or prior attempts. Phase III will provide the results of a review of evidence-based practices for suicidal clients. Finally, Phase IV will be the integration of the results to develop the resource manual.

As explained the Methodology chapter, certain keywords and/or phrases were used during the literature search. Only results that met inclusive criteria (i.e. suicide AND adolescents, suicide intervention AND adolescents, evidence based practice AND suicide, evidence based suicide intervention, suicide AND Latinos/as, suicide AND Hispanics, adolescent suicide AND Latino/as, suicide intervention AND Latino/a OR Hispanic/Hispanic adolescents, risk factors AND suicide AND adolescents, suicide risk factors AND Latino/a OR Hispanic/Hispanic adolescents, suicide protective factors AND adolescents, suicide protective factors and Latino/a OR Hispanic/Hispanic adolescents) were reviewed for this dissertation. In total, 348 abstracts were identified and screened for inclusion in a larger database. Of these, 21 trials fulfilled the inclusion criteria for the current review. Figure 1 lists the number of results for each combination of keywords related to each topic:

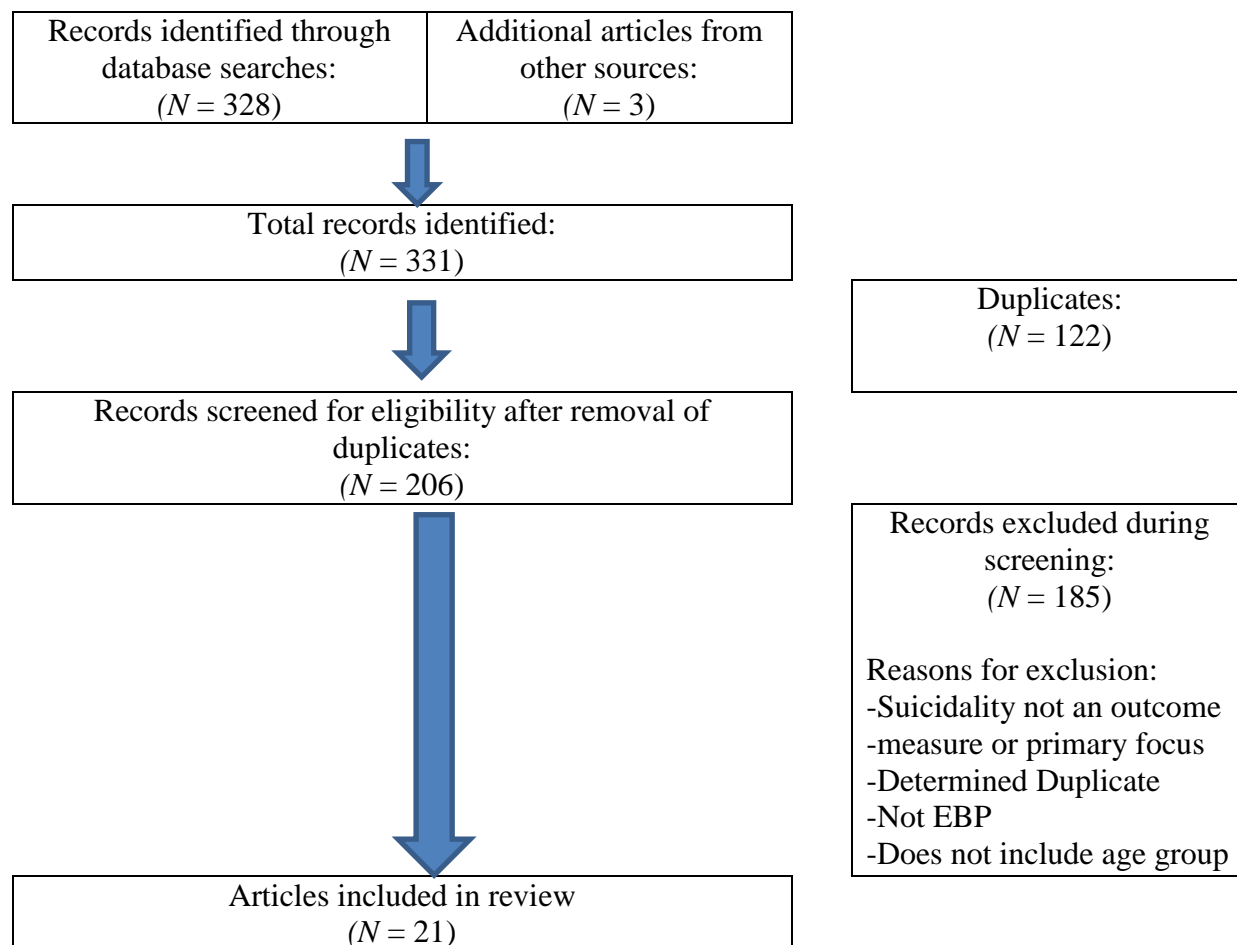


Figure 1. Study identification flow diagram for risk and protective factors for Latino/a adolescents.

A number of patterns and notable occurrences were found during this search. For example, when searching for keywords adolescents AND suicide, which is much more generic, there was expectedly a large number of sources ( $n = 11,458$ ) that arose for a variety of topics. For example, some explored adolescent suicide among the LGBT community, analysis of suicide patterns among adolescents over the past few decades, and trauma. However, when searching under the child development and adolescent studies category and keywords suicide AND Latinos are entered, only 158 results emerge. Among these results, suicidality is studied as a secondary effect of a different psychopathology such as depressive or aggressive behaviors. These discrepant results highlights that the need for resources for this population exceeds the research

needed to make those effective resources available. This dissertation hopes to contribute to this need by utilizing what resources that were available by first analyzing the data much more closely about what is understood about suicidal risk within the Latino/a youth population (Phase II).

### **Risk and Protective Themes for Latino/a Adolescents**

The next section is Phase II of this dissertation, which explored risk and protective factors further to inform how interventions can be best tailored. Common risk and protective factors for this population were briefly discussed and explored in the Literature Review chapter to highlight the strong need for a culturally tailored manual. This section will provide a more in-depth exploration of these themes by also determining how these factors raise and/or potentially lower the risk for these individuals. As previously stated, it was anticipated that risk and protective factors were two separate entities to be evaluated separately; however, upon exploration of the literature, the interconnectedness of each category made it more difficult to view them separately. Each category is, therefore, described as a blend of the two and highlights areas of importance when considering culturally-tailored interventions. These factors will be underlined to easily point out elements that will be included in the manual. This knowledge will help to identify potentially modifiable risk or protective factors that can be the target of preventative interventions (Joe, Canetto, & Romer, 2008).

**Cultural attitude towards mental health.** Before exploring how mental health is perceived among the Latino/a community specifically, it is important to have an understanding of the more general societal attitude of mental health, which also strongly influences how specific groups interpret those perceptions. Sociological theories explain the creation of stigma based fundamentally on the idea that interpersonal interactions are socially constructed; stigma

then becomes present when there is stereotyping, separating, and discriminating of others (Thornicroft, 2013). Stigma's close interconnection with discrimination of certain individuals therefore impacts their interaction with other members in their society. In addition to experiences of direct discrimination from others, people with mental illness might be particularly disadvantaged through structural or systemic discrimination (e.g. a lesser investment of health-care resources allocated to the care of people with mental disorders, than to those with physical illnesses; Thornicroft, 2013). Furthermore, people with mental disorders also often experience unequal treatment for physical health conditions, which could contribute to an increase in morbidity and premature mortality (Thornicroft, 2011). Within health-care settings, stigma can manifest as a violation to fundamental human rights including the right to health (United Nations, 2006). Poor quality of care can in turn act as an important barrier to help-seeking by people with mental illness and their family members. For example, people with mental disorders might delay or stop seeking treatment or terminate treatment prematurely for fear of labelling and discrimination, or because of experiences that treatments are not effective or respectful locally available or acceptable alternative (Clement et al., 2015).

Stigma and discrimination also affects family members, also known as *stigma by association*, or *affiliate stigma*. This form of stigma can lead to direct discrimination, feelings of shame, and self-blame, much like the internal consequences of mental health stigma faced by people with mental disorders (Thornicroft, 2015). In societies where the cohesion of family networks is strong, the effect of stigma by association can be more severe (Thornicroft, 2011). For cultures with a more collectivistic foundation where family cohesion is emphasized, this form of stigma becomes magnetized. As we have seen in research for Latino/a cultures, this



family-centered value, or familismo, can influence how an individual with mental illness, as well as their family, be negatively perceived.

It is then not surprising that when exploring research on connecting the Latino/a community to mental health, that there are numerous challenges that come to light. This is primarily because recruiting special populations that are not likely to appear on the more general radar screen of clinical epidemiologists and researchers. Working with adolescents, particularly, also requires special effort to guarantee voluntary recruitment, and the most frequently reported difficulty is obtaining parental consent (Diviak, Curr, Emery, & Mermelstein, 2004). Parents also strongly influence their adolescents' decisions to participate in research and mental health services (Broome & Richards, 2003). Therefore, it would be incredibly valuable that when developing a manual and implementing any intervention for suicidal Latino/a adolescents that there be an ability to establish a good relationship with not just the adolescent, but with the parents or caregivers as well.

In addition to building strong rapport with the family, numerous studies provide good evidence of factors that can improve this population's attitude towards general mental health and seeking services to improve it. For example, the literature provides a consensus that interventions with social contact or first person narratives were more effective than others; another example from a study by Corrigan and Watson (2002) shows that providing psychoeducation and factual data about the occurrence of mental illnesses moderately disconfirms a pre-existing stereotype. They further concluded that live contact was superior and more effective than non-direct education (i.e. films, brochures). When considering this data in the context of the resource manual, it is important to consider that the manual be used while the adolescent and their family has direct and live contact with their mental health provider when possible. This facilitates a

reciprocal relationship to discuss their cultural preconceptions and stigmas towards mental health, for the therapist to provide psychoeducation, and promote engagement and collaboration within their therapy. Providing opportunities for the client and the family to discuss their experience in a first person narrative can also increase the efficacy of this therapeutic process.

**Cultural attitude towards suicide.** Throughout many cultures and generations, there still exists a more specific form of stigma around the topic of suicide. Greater understanding of the cultural context of mental health issues, especially suicidal behavior, may help psychologists to improve access to and decrease barriers to treatment, address needs for culturally competent therapists, and improve quality of care for vulnerable populations (U.S. Department of Health and Human Services [DHHS], 2001). From a broader standpoint, suicide is often a taboo subject that many individuals, whether affected by it or not, are likely not going to discuss with others out of fear and shame. Queralt (1993) interviewed parents of adolescents who died by suicide, and found that four of the 11 relatives (36%) had not accepted the suicide ruling and insisted that their children had been victims of foul play or had killed themselves accidentally. The researchers noted that these parents appeared troubled by or angry about the suicide determination. They hypothesized that perhaps they were unwilling to admit the suicide to a stranger for various reasons, including shame, or fear of blame (Queralt, 1993). Whatever the reason, there was strong evidence from the researcher's experience that some of the victims' parents found the word *suicide* unacceptable in referring to the circumstances of their children's deaths (Queralt, 1993).

Further exploration also finds how shame and social stigma of suicide can even impact the data gathered to understand its true impact on various populations. While the numbers are provided about incidences of suicide in various regions, there is strong evidence to suggest that

even those reports may be underreported due to social stigma of suicide. International misclassification of suicide, particularly undercounting, has long been a scientific concern (Rockett, 2010). Some research found that professionals, such as medical examiners, themselves have hesitations to declare cause of death by suicide, especially among younger individuals. One study by Rockett et al. (2010), found plausibility of this occurrence related to precluding or minimizing social stigma as their results demonstrated medicolegal authorities may be more protective of families of younger people than older people who commit suicide. Some scholars and researchers contend that suicide rates are actually socially constructed, and that the greater the social condemnation of suicide and the smaller the community support for suicide investigations, the more deficient the reporting. Moreover, it may similarly function to encourage family and friends, and sometimes even professional authorities themselves, to withhold or suppress crucial evidence like a suicide note, or knowledge of behavior or conversation consistent with suicidal ideation (Rocket, 2011).

When looking at suicide rates in Latin American countries, it then seems reasonable that there also will be a substantial number of undetermined deaths, which were probably suicide and underreported. If we assumed that half the undetermined deaths might be re-designated “suicides,” then the annual tolls are even more daunting – in excess of 4,800 people dying annually in Argentina, 3,500 in Colombia, 5,300 in Mexico; and 31,000 in the USA (Pritchard & Hean, 2008). Many governments of the major developed countries have recognized that suicides are often preventable and have made commitments to try and reduce these depredations (Department of Health, 1999). These results provide evidence that in Latin America, as elsewhere, the task of suicide prevention has never been more important or more urgent, especially for adolescents. It is feared that the traditional cultural attitudes in the majority of the

Latino/a community are significantly impacting how suicidal individuals, particularly adolescents, will be perceived by their environment. Not only are mental health services underutilized by Latinos/as, but the array of apprehensions and misperceptions of Latinos/as surrounding mental health services may curtail their efforts to reach out for help when they or a loved one is suicidal (Cabassa, Lester, & Zayas, 2007).

The next step would be to explore how this fear and stigma surrounding suicide can actually impact the behavior of a person who is suicidal. Research is very limited but much needed to understand the ways through which stigma around suicide can act as both a risk and a protective factor. Research suggests an interesting paradox that, on the one hand, stigma appears to prevent suicidal behavior (Early & Akers, 1993) and, on the other hand, it interferes with help-seeking behavior by suicidal individuals and significant others (Goldsmith et al., 2002). Studies supported that stigma interfered with participation and with sustaining the long-term success of a suicide prevention program (Joe, 2008). There lacks further exploration that focuses on reducing the stigma of suicide or whether it should be a part of suicide prevention strategies, particularly for ethnic minority populations. Allowing the client to have a safe space in therapy, however, can encourage a candid discussion and open narrative of how they perceive suicide and how it has impacted their behaviors related to those ideations.

**Help seeking behaviors.** Based on the review of the literature thus far, there exists strong evidence that demonstrate how attitudes and stigma related to suicide and mental health in general can influence how a person seeks help and where they go. As mentioned above, behaviors such as suicide attempts may be perceived, labeled, or tolerated differently in different cultural groups (Cauce et al., 2002). Even if a behavior is recognized as problematic, cultural factors can affect decisions about whether to seek mental health assistance. Attitudes toward

help-seeking then becomes critically important for tailoring effective suicide prevention methods to Latino/a cultures.

Help-seeking is a critical link between understanding there is a problem and receiving necessary support or services from formal (e.g., mental health professionals) or informal sources, such as parents or peers (Srebnik, Cauce, & Baydar, 1996). Available data indicate that there is a low rate of help-seeking within ethnic minority groups with less than one in five individuals seeking care from a mental health professional for mental health problems (U.S. Department of Health and Human Services [DHHS], 2001). Compared to other ethnic groups, Latino/a young adults are the least likely to receive care from a mental health specialist even when care is sought (DHHS). Culture additionally may affect each of the stages of help-seeking behaviors (Cauce et al., 2002) that lead to utilization of mental health services for prevention or treatment of suicidal behaviors. Structural factors in the service-delivery system that inhibit help-seeking and service use among Latino/a suicide attempters include negative experiences with service procedures (e.g., not understanding and lack of explanation of emergency room procedures) and feeling blamed for the youth's attempt (Rotheram-Borus et al., 1996). Kataoka, Stein, Lieberman, and Wong (2003) found that when adolescent Latinas seek help for such problems as depression, family, and relationship problems, they are more likely to turn to informal sources such as peers and family (Rew, Resnick, & Blum, 1997). Additionally, newly immigrated Latinos lack familiarity with the service system and are often apprehensive of it because of fear of being reported if they are undocumented.

In sum, suicidal behavior and help-seeking occur in a cultural context and are likely associated with different precipitating factors, different vulnerability and protective factors, differing reactions to and interpretations of the behavior, and different resources and options for

help-seeking. Awareness of the interface of culture, adolescent suicidal behavior, and help-seeking is essential for professionals and an important step en route to the development of effective culturally sensitive interventions to reduce suicidal behaviors. In developing this manual, it is presumed that the individual seeking treatment is already linked with a mental health professional who is planning to utilize the Resource Manual. The key features of help-seeking behaviors from a cultural lens can, however, promote adherence to treatment by considering and discussion potential hesitations to continue with treatment.

**Access to care.** As discussed in the Literature Review chapter, there are many barriers to treatment that can prevent or limit a Latino/a adolescent's accessing help. In terms of mental health, Latinos/as have been shown to have lower access to health care and use poorer quality of mental health care than European Americans (Kessler, Berglund, Borges, Nock, & Wang, 2005). This can manifest in numerous ways, in addition to stigma and lack of trust of the mental health care system. For example, a study by Zayas, Hausmann-Stable, and Pilat (2009) found that they frequently encountered scheduling conflicts between their availability and the clinics' working hours. Requests for childcare and transportation arrangements were frequently difficult to fulfill, especially for a geographically dispersed population. Compounding these issues was the fact that some of the study's participants were undocumented immigrants, particularly the parents. Hesitation about participation was evident in parents' replies to research invitations, and they expressed interest very tentatively until trust was established. To achieve higher levels of engagement, researchers found it to be more beneficial to adjust the interviewing process to the parents' requests, especially. Interviewing on weekends or in the evenings, obtaining consent in the participants' homes, and providing childcare during these interviews were all crucial to increase our rate of data collection (Zayas, Hausmann-Stabile, & Pilat, 2009).

The results of this study supports the greater need for field-based or home-based services to accommodate for families that may have logistical barriers, such as finding child care, restrictive work schedule, and transportation. If clinicians are available they are encouraged to offer ways to accommodate these families as best as they can; examples can be providing services at their home, or at their school. At the very minimum, initiating a discussion with the adolescent and their family to address potential concerns and collaborating to problem-solve ways of addressing those barriers is strongly encouraged. These discussions and communication would then be beneficial in continuing encouragement of a client's consistent attendance to treatment if a known plan is discussed and implemented should barriers arise in the future.

**Immigration, assimilation, and acculturation.** The impact of immigration and acculturative stress on individuals has been widely explored. Approximately 21% of Latinos/as in the USA are first-generation, 13% are second-generation (having at least one first-generation parent), and the remaining 66% are later-generations (US Census Bureau, 2012). While there are still a number of people who have immigrated to the U.S. within their lifetime, there is an increasing amount of U.S. born Latinos/as that are changing the evolution of assimilation. It is, therefore, not surprising that studies have been done to specifically try to understand and identify how acculturative stress and assimilation can contribute to a person's risk for suicidal and/or self-harming behaviors. As a result, these studies have noted some interesting and even surprising factors that are essential in exploring as this manual is developed.

It is clear that there is a strong need for understanding how this characteristic is connected to suicidal behavior to improve prevention efforts for Latino/a adolescents. Acculturation is defined as the processes of change in artifacts, customs and beliefs that result from the contact of societies with different cultural traditions or the results of such changes

(Escobar and Vega, 2000). Using this classification, we can better understand what is known as the Intergenerational Cultural Conflict (ICC; Lui, 2015). Some researchers hypothesized from their results that when there are conflicting expectations at the macrosystem and microsystem levels, it may pose culture-specific challenges for the immigrant groups that are not commonly seen among nonimmigrant groups in the United States (Coll et al., 1996). In other words, an immigrant individual's personal experience, as well as their experiences within a larger societal context, can differ from a non-immigrant individual; there is, therefore, a gap in their unique expectations of other family members as well as a conflict in understanding the different challenges that arise. Culture thus takes a central stage in its influence on immigrant groups' intrapersonal adjustment, interpersonal relationships, and interactions with other systems (Jiang and Peterson, 2012).

Among the many risk factors influencing adolescent suicidal behavior (e.g., family history, peers, and stress), depression, problematic alcohol use, and illicit drug use are three of the most important. The strong association between these three factors and suicide attempts among adolescents has been replicated across multiple studies (Gould, 2003). Because all three factors are also serious public health concerns in their own right, researchers have started to examine their relation with immigrant generation status. Evidence is growing that immigrant generation status is related to mental health outcomes including substance use and depression. Peña and colleagues (2008) used a subset of the data from the National Longitudinal Study of Adolescent Health ( $n = 3135$ ) to evaluate this trend. By looking at adolescents who endorse Latino/a descent and fit in a category of first, second, or third generation, they found that their immigrant generation status was, in fact, a determinant for suicide attempts. Most notably was that 2<sup>nd</sup> generation Latino/a adolescents were 2.87 times more likely to attempt suicide than 1<sup>st</sup>



generation, or immigrant, youth. Later generations (3<sup>rd</sup> and up) had even higher risk as they were 3.57 times more likely to attempt than 1<sup>st</sup> generation adolescents. Additionally, rates for suicide attempts among first-generation Latina females (ages 12 to 17) were lower than for US-born generations of Latina females in a national sample (SAMHSA, 2003; Peña et al., 2008).

However, only limited inferences regarding reasons for the observed reductions in suicidal behaviors of first-generation youth can be drawn on past findings without a broader discussion of three scientific areas of study in the literature: (a) risk factors for suicidal behavior, (b) empirically derived associations between risk factors and generation status, and (c) conceptual models regarding the relation between acculturation and mental health (Peña, 2012). Further and more specific exploration of the literature related to acculturation can help to identify how an individual's immigration generation status impacts their risk for suicide.

These results beg the question, "why?" Several conceptual models have been proposed to explain why first-generation Latinos have better mental health outcomes than US-born generations, including suicide and its related risk factors of substance use and depression. Given the amount of complexities and confusion people experience when immigrating into a new country, it is often assumed that immigrants are more vulnerable to mental health issues. Despite common beliefs that acculturation poses stresses to immigrant groups (Brondolo, Gallo, & Myers, 2009), research has shown that the opposite is true; in fact, the literature repeatedly and consistently identifies that foreign-born ethnic minority groups and immigrant groups who are less acculturated to the American mainstream are less likely to have poorer mental health outcomes than their native-born and more acculturated counterparts (Gupta, Leong, Valentine, & Canada, 2013). This phenomenon, also known as the *immigrant paradox* highlights just how complex the relationships among acculturation, and effective and ineffective navigation of

resources are in the context of developing a culturally-inclusive manual. A model developed by Peña et al. (2009) explored this question of the *immigration paradox* and categorized into three types referred to as (a) the Protective Culture Model, (b) the Resilient Immigrant Model, and (c) Intergenerational Acculturation Conflict Model, which was discussed earlier in this section. These models are not mutually exclusive. Their descriptions below are not meant to be comprehensive reviews, but rather brief overviews.

The Protective Culture Model suggests that aspects of Latino/a culture decrease risk for suicide or protect against factors associated with suicide. Catholic countries have lower rates of suicide than Protestant countries because they have greater levels of social and family bonds. Others make similar arguments regarding Latino/a culture—that high levels of family and social support are protective against suicidal behavior or reduce the effect of other risk factors, such as acculturation stress (Canino & Roberts, 2001). Portes and Rumbaut (2001) also discuss how maintaining elements of Latino/a culture, especially within ethnic enclaves, protects against factors such as racism and reduces the likelihood of drug involvement among youth. This model also suggests that protective cultural attributes dissipate with time spent in the USA, thus offering a possible explanation for lower rates of suicide attempts as well as drug and problematic alcohol use among first-generation youth compared with later-generations.

The Resilient Immigrant Model suggests that the immigration process favors the inclusion of individuals with relatively high resiliency and good mental health over those who lack resiliency or who have mental health problems. This explanation has been offered as a potential reason why immigrants tend to have better mental health outcomes than their US-born counterparts (Burnam, Hough, Karno, Escobar, & Telles, 1987). Further extensive research found what is known as the *healthy immigrant effect* (Lui, 2015), which shows that effective use

of personal and social resources, and coping mechanisms contribute to immigrant groups' successful adaptation to a mainstream culture during acculturation and immigration (Hobfoll, 2002). Most evidence on the healthy immigrant effect centers on the protective role of supportive and coherent family and extended social networks (Crockett et al., 2007), strong ethnic identity (Smith and Silva, 2011), and bicultural acculturative strategies (Yoon et al., 2013) on mental health and educational outcomes. For instance, active coping, as opposed to avoidant coping, was found to buffer the deleterious effects of acculturative stress on depression and anxiety among Latino/a Americans (Crockett et al., 2007).

These results beg the question of what challenges are present for non-immigrant adolescents? It is clear that cultural expectations and experiences clearly define and shape how individuals navigate their resources to optimally adapt to the larger cultural contexts (Ting-Toomey et al., 2000); but the next question is to explore in what way this happens? A mixed-methods study indicated that Latino/a Americans identified bicultural competence (including ambition and desire to succeed, capacity to relate to family and friends, and maintaining the traditional Latino/a culture) as active and collective coping skills to successfully navigate the juxtaposition of two seemingly different cultural contexts (Becker et al., 2012). Latino/a adolescents have the additional challenge of defining and integrating their ethnic identity within Euro-American society, usually in the face of acculturative stress, racism, discrimination, and oppression (Trimble, Helms, & Root, 2003). Moreover, acculturation has been associated with increased family conflict and reduced family cohesion in Latino/a families (Miranda, Estrada, & Firpo-Jimenez, 2000), and family functioning has been linked with depressive symptoms in Mexican-origin youth (62 % U.S. born; Gonzales, Deardorff, Formoso, Barr, & Barrera, 2006) and a diverse sample of Latino/a adults (Lorenzo-Blanco, Unger, Baezconde-Garbanati, Ritt-

Olson, & Soto, 2012). It is, therefore, possible that acculturation leads to increased depressive symptoms in Latino/a youth through loss of Latino/a cultural values that, in turn, may lead to lower family cohesion and higher family conflict. Strong interpersonal relationship building skills can thus potentially promote social support and cultivate a sense of ethnic identity, which are both beneficial to the mental health of adolescent ethnic minority individuals (Smith & Silva, 2011). Immigrant families must contend with the generational gaps and the stress of acculturation. At the heart of it are the relationship between immigrant parents and their children and the contradictions that are often engendered in the process of seeking to fulfill the hopes and desires of both.

**Familismo.** An important Latino/a cultural value that has been well-documented in the empirical literature is familismo (Sabogal, Marín, Otero-Sabogal, & Van Oss Marín, 1987). As previously defined, the concept of familismo values closeness and interconnectedness between immediate and extended family members (Marín & Gamba, 2003), as well as loyalty and solidarity in the family system (Marín & Van Oss Marín, 1991). In addition, familismo refers to the responsibility and obligations that family members feel toward each other (Sabogal et al., 1987), in part reflecting the collectivistic orientation in Latino/a culture (Antshel, 2002). Its cultural value emphasizes an interconnected and interdependent relationship within the family system. Given the emphasis on family support and close relationships, it can quickly be seen that this cultural value has the extremely powerful potential in playing a protective factor in preventing and reducing risk for suicidal behaviors for Latino/a adolescents.

While research does support this notion, there are other elements to this concept that can also create tension and stress, which could potentially increase an individual's risk. For example, the literature highlights a strong correlation between acculturation and familismo in that

acculturation can impact the determination of how and where familismo is placed on the spectrum of protective factors for suicidality. Like acculturation, familismo is a multidimensional construct, and overlaps very closely with aspects of acculturation in developing a sense of cultural identity. Research has suggested that familismo influences both attitudinal and behavioral norms (Rodriguez and Kosloski, 1998), especially with behaviors related to mental health and values towards suicidal behaviors. At the microsystem level, familismo reinforces deference to parents, restrictions on adolescent female autonomy, and family unity, whereas at the mesosystem level, U.S. cultural norms result in increased adolescent autonomy (Zayas, Lester, Cabassa, & Fortuna, 2005). Zayas et al. (2005) theorized that migration, acculturative stress, discrepant levels of acculturation, Latino/a sociocultural factors, socioeconomic disadvantage, traditional gender role socialization, ethnic identity, and adolescent–parental conflict (influenced by family functioning) are all factors that can lead to suicide attempts. More specifically, researchers propose that acculturation, in particular, is often accompanied by a deterioration in family functioning through a loss of Latino/a cultural values which are thought to promote family cohesion and discourage family conflict (Gonzales et al. 2006; Zayas et al. 2005). Moreover, acculturation has been associated with increased family conflict and reduced family cohesion in Latino/a families (Miranda et al., 2000), and family functioning has been linked with depressive symptoms in Mexican-origin youth (62 % U.S. born; Gonzales et al. 2006).

It is, therefore, possible that acculturation leads to increased depressive symptoms in Latino/a youth through loss of Latino/a cultural values that, in turn, may lead to lower family cohesion, or sense of familismo, and higher family conflict. From a developmental perspective, Latino/a adolescents seem to be more deeply troubled by such questions as “Who am I? Who do

I want to be, versus who does my family want me to be?’’ than do their peers of other ethnic backgrounds. This is a common dilemma during adolescence, which seems to be intensified in this group due to the two contradicting cultural traditions surrounding them (i.e., the American mainstream individualism versus Latino/a culture’s collectivism and familismo). This process may explain why Latino/a youth’s mental health is affected negatively by acculturation and why girls’ mental health is affected more negatively by acculturation than is the mental health of boys. Latino/a cultural values were associated with family cohesion and conflict but the strength and direction of these relationships varied across cultural values and gender. For girls and boys, familismo and respect, or *respeto*, were associated with higher family cohesion and lower family conflict. These results indicate that improving family functioning will be beneficial for boys’ and girls’ psychological well-being. This may be achieved by promoting familismo and respeto for boys and girls and by promoting traditional gender roles for girls (Lorenzo-Blanco et al., 2012).

Finally, different from acculturation is the concept of *enculturation* and its interaction with the value of familismo. Enculturation is defined as a process by which Latino/a youth learn and engage in the practices, values, and identifications of their Latino/a culture (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). Gonzales et al. (2006) studied the impact of enculturation and found that, unlike acculturation, it can actually strengthen the family dynamic of a Latino/a adolescent. For Latino/a youth, family support may serve as a protective factor from acculturative stress (Canino & Roberts, 2001) through this concept of enculturation. Specifically, tight-knit Latino families may constitute the first line of defense in helping a member cope with suicidal thoughts, especially those with a history of trauma (Oquendo et al., 2005).

**Latinas.** A critical detail of the statistics of Latino/a adolescent suicide is the alarming

rate to which Latinas, specifically, are at risk. Latinas reported the highest rate of suicide attempts in comparison to Caucasian and African American adolescents (Centers for Disease Prevention and Control, 2015). Among Latina teens, the 12-month prevalence of attempted suicide is 15.6% (Centers for Disease Prevention and Control, 2014). Due to their extreme vulnerability to suicide attempts, much of the literature has explored contributing factors through a gender perspective, which acknowledges the different socialization of boys and girls that could lead to identifying distinct pathway to suicide behavior. While this may not describe the roles and hierarchies for all Latino/a families, gender can be a big determinant of family roles and responsibilities in many Latino/a families (Cauce & Domenech-Rodriguez, 2002). As result, the gender expectations and experiences are different for the girls and boys within these family structures. In general, findings suggest that girls are required to provide more assistance at home and receive greater supervision and restrictions on activities outside the home (Umaña-Taylor & Upderaff, 2007).

Interestingly, when considering this gender perspective, there appears to be a strong connection between suicide risk among Latinas and family conflict. In the literature on Latina teens' suicide attempts, research consistently demonstrates that stressed relations between attempters and their parents seem to be a common factor (Zayas, Gulbas, Fedoracvicius, & Cabassa, 2010). Past attempters characterized their family relationships as tense or weak, stemming from poor communication, mentoring, and/or support (Zayas & Gulbas, 2012). Some of these characteristics that increase conflict and lead to triggers preceding an attempt include differences in perceptions of parenting style, respectful behavior, adolescent autonomy, and the allocation of household rules (Gulbas, Hausmann-Stabile, De Luca, Tyler, & Zayas, 2015). In its most extreme form, family conflict can engender violence, and many Latina teens decide to

attempt suicide in the wake of violent family trauma (Zayas et al., 2010). Family conflict can be especially burdensome to Latina adolescents because it contradicts salient cultural values that posit the family as a cohesive, harmonious, interdependent social unit (Romero, Hondagneu-Sotelo, & Ortiz, 2014). This puts pressure on the Latina adolescent to espouse a value orientation that is “household-centered rather than child-centered” (Gulbas, 2015). Yet, the capacity to uphold this cultural value is context-dependent. When Latino families endure stressors, such as underemployment, discrimination, or fragmented social structures, parents and adolescents sometimes find themselves unable or unwilling to provide family support (Zayas & Gulbas, 2012). Using this cultural framework, attempted suicide by Latina teens can be understood as an act that speaks not only to the psychosocial state of the individual, but also of the family: Individual distress is a family affair, whereas family suffering is deeply felt at the individual level (Zayas & Gulbas, 2012). In understanding how this impacts the Latina adolescent, when including cultural values during treatment, the clinician should place a large emphasis on the family value and potential stressors that can act as potential triggers.

**Cultural expression of distress.** In understanding suicidal behavior among Latino/a adolescents, it is important to consider cultural expressions of distress. Research findings underscore the importance of gaining a better understanding of developmental processes and psychological functioning among this rapidly growing and young population. The expression of distress through somatic symptoms has been observed in many groups, including Latinos/as (Escobar, Burnam, Karno, Forsythe, & Golding, 1987). Early research, influenced by psychodynamic theory, suggested that the expression of psychic distress via bodily complaints reflected limited psychological development (Escobar et al., 1987). Current perspectives, however, accept somatic and psychological forms of expressing distress as equally valid. The



critical questions today concern how social and cultural processes shape the expression of distress that emphasizes the soma, the psyche, or both (Kirmayer & Young, 1998).

The overarching purpose of this section was to include research that investigates Latino/a adolescents' psychosocial functioning (i.e. self-esteem and depressive symptoms) from a culturally-informed perspective (Coll et al., 1996) by considering the central role of culturally-relevant stressors (i.e. discrimination) and experiences (i.e. ethnic identity processes, cultural expression). The term *nervios* (nerves) refers to a culturally based somatic expression of anxiety or other emotional distress, which is differentiated from more severe pathology (e.g., schizophrenia, psychotic disorders), referred to as *locura* (craziness) or *fallo mental* (mental failure or defect). Zayas and colleagues (2005) have postulated that the behaviors of young Latina suicide attempters bear similarities to the phenomenology of *ataques de nervios* (e.g., dissociative experiences with loss of control and, sometimes, suicidal behaviors). Ataques are often brought about by a stressful event perceived as a threat to family integrity. Clinical observations suggest that similar types of family relational disruptions that precipitate ataques de nervios may also be operative in the suicide attempts of adolescent Latinas.

Some research has examined the extent to which Latinos express physical symptoms, particularly in comparison to Whites. Many of these studies have used symptom indices derived from the diagnostic interview used in the ECA studies. According to these studies, Mexican American women, particularly those over age 40, are more likely to report somatic symptoms; however, no differences were found between Mexican American and white men (Escobar & Vaughan, 2014). In an additional study, Puerto Rican men and women had higher rates of somatic symptoms than Mexican American and non-Latino/a men and women (Escobar et al., 1987).

A group of primary care patients that included Central American immigrants, Mexican immigrants, U.S.-born Mexican Americans, and Whites were assessed for psychiatric disorders and somatization. After controlling for education and income differences, the immigrants reported fewer psychiatric disorders but higher rates of somatic symptoms when compared with the U.S.-born sample (Escobar & Vaughan 2014). However, a study by Villaseñor and Waitzkin (1999) questioned the validity of those findings that differences in use of health care services, different cultural understandings of the questions, and differences in socioeconomic status lead to spurious reports of somatic symptoms. For example, symptoms could have been considered “medically unexplained” because Latinos failed to receive adequate medical care and did not receive a diagnosis from a physician. Of particular significance are service factors (accessibility to care) and cultural factors (the meaning of physical and mental health) as they relate to somatization and distress. It is, therefore, important that cultural expressions of distress, such as somatic symptoms, can indicate the presence of psychological distress; this, in turn, can suggest a potential risk for suicidal ideation and should be considered and discussed with clients as they describe their symptoms and pain. Inquiring about triggers or pain and prior forms of treatment can provide essential detail if their distress is related to psychological pain that is impacting their daily functioning.

**Discrimination.** Numerous research findings indicate that racism and discrimination result in stress that adversely affects physical and mental health (Duarté-Vélez & Bernal, 2007). Historical experiences of migration and the context of how the different groups of Latinos/as were received in the United States play an important role in ethnic identity and current health status (Bernal, Trimble, Burlew, & Leong, 2002). Research supports a positive correlation between perceived discrimination and depressive symptoms among Mexican-American and

Puerto Rican adolescents (Umaña-Taylor & Updegraff, 2007). Additionally, their further findings suggest that “perceived discrimination is a common experience for Latino/a adolescents and moreover, that perceived discrimination is associated with poor mental health” (p. 566). Among females, Latinas report significantly higher risk for depression than their Euro–American peers (Guiao & Thompson, 2004). It can be, therefore, understood how discrimination can be a big risk factor for this particular community as it has the potential to cause significant stress.

Upon further attempts to understand how discrimination and depressive symptoms interact, it is stalled by the lack of studies exploring how to use this information with intervention. In other words, knowing that discrimination is a big stressor, finding factors that counter its effect (i.e. risk reducers), should be considered (Umaña-Taylor & Updegraff, 2007). From a risk and resilience perspective, self-esteem and ethnic identity are considered as potential “mediators between the influence of discrimination on depressive symptoms” (p. 451). Adolescents who have explored and resolved issues regarding their ethnicity may feel more confident and have the tools with which to discuss issues pertaining to ethnicity, when compared to those who have not explored or resolved the meaning of their ethnicity (Umaña-Taylor & Updegraff, 2007). The authors found that there is potential in the resource to support this theory and encouraged it to be further explored. There are, however, no available studies to further support this theory. It does show some encouragement and begins the discussion of positive and strength-based characteristics of the adolescent as combatants against suicidal behaviors.

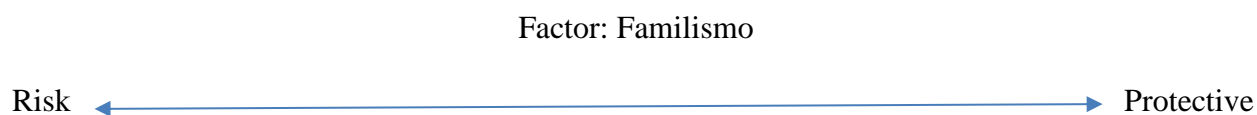
**Religion.** One hypothesized factor that is thought to influence suicide risk among Latinos/as is religion. There are, however, no studies that have specifically explored the relationship between these two variables. Other studies, however, have found that religion among Latino/a adults can significantly reduce other harmful behaviors, such as substance use

(Edwards & Romero, 2008). One theory is that attendance of religious services and events could promote conformity to norms against substance use, reduce time for engagement in substance use, and provide a source of stability and support in the individual's life (Ford & Kadushin, 2002). In addition, religious importance may be related to the internalization of pro-family norms that may help the individual cope with stressful situations in more pro-social ways that do not involve substance use (Stolzenberg, Blair-Loy, & Waite, 1995). The promotion of pro-family norms may have a particularly salient impact on Latino emerging adults due to the cultural value of familismo (Santiago, Rivera, Arredondo, & Gallardo-Cooper, 2002). This can potentially also apply to other harmful behaviors, such as suicide; but it cannot be confirmed based on the lack of research.

Barranco (2016) attempted to close this gap by comparing research of each separate variable (religion in Latino/a culture and suicide) to build an idea of how they interact. Results of the study showed three key pieces: 1. religious contextual variables significantly affect Latino/a suicide rates; 2. U.S.-born Latinos/as benefit from religious communities, regardless of denomination or measurement used; and 3. foreign-born Latinos/as only benefit from Catholic adherents and homogeneity (Barranco, 2016). While there is very limited research on this, there is no denying the strong impact of religion among various generations and diversities within the Latino/a community. It should therefore still be considered and discussed with individuals to determine if religion is a protective factor incorporating support, spirituality, and a sense of purpose.

**Summary.** Many common themes arose as literature was reviewed for this phase of the dissertation. Before these are summarized, it is important to highlight a pattern that arose when looking at risk and protective factors. Many of these factors were similar and exhibited a lot of

overlap (i.e. religion, familismo and family expectations, etc.). This demonstrates the fact that these concepts are more interrelated than what was previously thought and cannot be thought of as completely separate constructs. Instead, they fall more along a spectrum of risk and protective factors versus two dichotomous categories. This is important for mental health professionals to consider in knowing that working towards ways to maximize each factor's potential to be a protective factor. For example, in Figure 2, the category of familismo is explored on a line representing a spectrum between protective and risk potential. Elements such as family values, expectations, roles, and support all fall somewhere on the line that can impact where on the spectrum familismo will ultimately land. For example, if expectations of the family is what hinders a youth from seeking help from their family, but their relationship with family is very strong and protective, that can be used to address the other factors. Interventions to thus consider are parent psychoeducation and incorporating family values into safety planning for that individual. In Figure 2, a visual outline of viewing the factor as having both risk and protective factors is provided. Depending on each individual's experience, the degree to which where on the spectrum that factor plays on their lives will determine if it is more of a risk or protective factor:



*Figure 2.* Linear diagram showing degree of risk and protective level for familismo.

This is in contrast with what much of the literature commonly identifies as separate identities or factors. Some literature noted the interconnectedness, but it is the hope of this dissertation to continue the dialogue that these concepts should be considered as interconnected and not separate entities.

With this being said, the following summaries highlight key pieces of each theme that arose in the literature that will be integrated into interventions for suicidal adolescents:

1. Cultural attitude towards mental health. Inquiring about the cultural perceptions of mental health, especially among the family can impact how involved that individual and their support system can be in their treatment. Establishing strong rapport and trust can help build more positive attitudes toward seeking out professional help.
2. Cultural attitude towards suicide. Inquiring about the individual and their culture's perception of suicide provides insight for the therapist and the client of what thoughts and hesitations around stigma might be limiting or encouraging their use of resources to their fullest potentials.
3. Help seeking behaviors. Much like cultural attitudes toward mental health, the mental health professional's increased awareness of patterns and tendencies of where adolescents go to seek help when they decided to do so is helpful in appropriately addressing treatment and correct psychoeducation.
4. Access to care. Various studies have shown that access to mental health care is a noted challenge at times for various reasons, including transportation, lack of knowledge, or language barriers. This is particularly true for the parents and caregivers of adolescents and emphasizes the need to diversify how mental health care is provided to best accommodate their needs, such as providing services at home, school, etc. At the very least, a greater effort is needed on the part of the provider to initiate and engage in a discussion with the adolescent and their family to address potential concerns and problem-solve ways of addressing those barriers.

5. Immigration, assimilation, and acculturation. There are many elements within the scope of impact that immigration and acculturation plays on families. Because of the complexity of these issues alone, it is imperative that mental health care professionals engage in some conversation with the adolescent to discuss how these issues may or may not impact them and contribute to their stress.
6. Latinas. Awareness of the issues and higher risk of Latina adolescents is important when the client identifies as such. This not only is an important step when assessing for suicidality, but in asking questions about their experience as a Latina can validate their experience provide a safer space as a result.
7. Cultural expression of distress. Different cultures express and communicate their distress in various ways. Research commonly notes that somatic symptoms can indicate the presence of psychological distress. Following evaluations from medical providers, inquiring about triggers or pain and prior forms of treatment can provide essential detail if their distress is related to psychological pain that is impacting their daily functioning.
8. Discrimination. The negative correlation between discrimination and self-esteem can impact the severity of depressive symptoms. Therefore, coming from a positive and encouraging approach can minimize discrimination's negative effects on the individual.
9. Religion. There is a paucity of evidence in the literature that specifically explores how religion affects suicidal behaviors in Latinos/as, however, similar studies for other pathologies demonstrates some potential in its protective factor, especially as it encourages pro-social behaviors that are reinforced with the value of familismo.

### **Evidence Based Practices (EBP's) for Suicidal Behaviors**

The next phase (Phase III) of this chapter explores interventions that have strong research

to support their efficacy in reducing suicidal risk for adolescents; noting the gaps they exhibit will also be discussed to address potential barriers they present from the cultural-specific issues of this particular population. The prevalence of youth suicide has given rise to the development of a range of psychosocial interventions aimed at preventing and reducing suicidal behavior and promoting help-seeking and early identification of suicide in young people (Calear et al., 2016). Interventions for youth suicide prevention have been implemented in schools, communities and healthcare systems, and are designed to reduce risk factors for suicidal behavior, or to identify individuals at risk and provide pathways to treatment or support (Calear et al., 2016). Psychosocial suicide prevention programs have been delivered individually, or in groups, and have tended to be based on common therapeutic approaches, such as cognitive behavior therapy. Review of interventions for the specific purpose of this dissertation reported the effects of a wide variety of treatment covering assessment for suicidality, and both individual and group treatments. These include specific problem-solving interventions designed to increase engagement; cognitive-behavioral treatments targeting problem solving and affect management skills, family therapy, developmental group psychotherapy incorporating the techniques of problem solving and cognitive-behavioral interventions, dialectical behavior therapy, and psychodynamic group psychotherapy and others. PsycINFO and PubMed databases were searched to the end of May 2016 to identify the effectiveness of psychosocial interventions for youth suicidality. In total, 3,419 abstracts were identified and screened for inclusion in a larger database. Of these, 63 trials fulfilled the inclusion criteria for the current review.



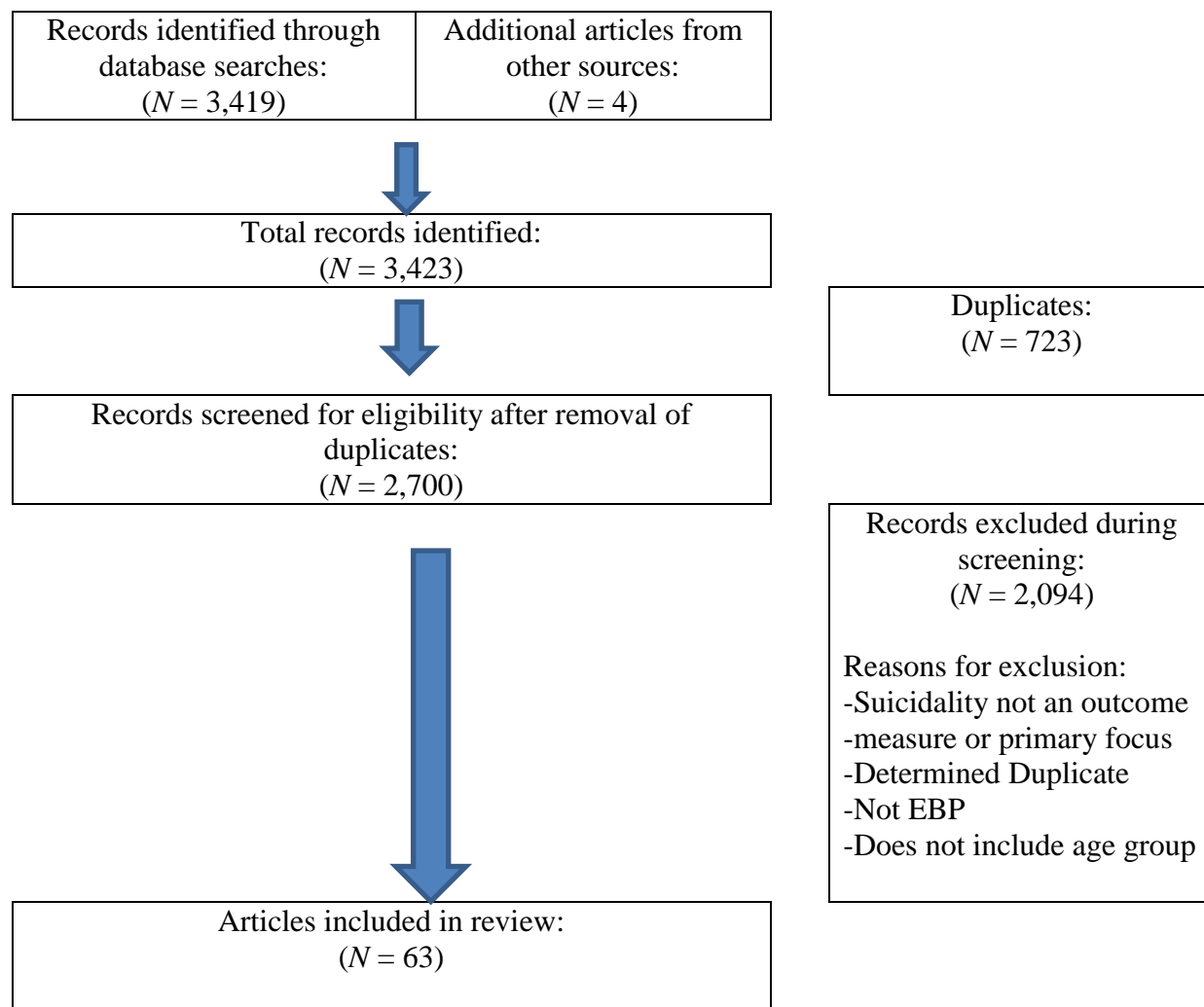


Figure 3. Study identification flow diagram for EBP interventions for adolescent suicide.

The current review provides preliminary support for the implementation of targeted interventions, using a diverse range of psychosocial approaches. Selective interventions are targeted to young people identified as being “at risk” of suicide, while indicated programs are designed for young people already exhibiting suicidal behavior, such as suicidal ideation or attempt (Katz et al., 2013). One noted challenge for this particular phase is that suicide prevention to a large extent lacks a preventative, strategic framework. To some degree this is due to a lack of a strong evidence-base around potentially effective strategies in a range of settings. The objective of the present review therefore is to identify psychosocial interventions

for youth suicide in healthcare settings, with the aim of identifying what types of interventions can be effective in these settings and where future research efforts should be directed. This information will then be integrated with the analyzed information of risk and protective factors for Latino/a adolescents.

### **Assessment Methods**

The first step is always to acquire a thorough assessment of the individual's current risk of suicide and relevant issues to help create hypotheses of their internal realities and guide the course of treatment. By developing hypotheses about the individual's operant schema, the therapist can, by direct questioning, work towards validating, modifying, or rejecting the original hypotheses (Freeman & Reinecke, 1993). Assessment is one of the most important tools to determine risk factors and ultimately, treatment goals for suicidal patients. Historically, research acquires statistical values among risk factors with large groups of individuals; however, this approach may not truly be accurate because some predictors are found among many individuals who are not suicidal, thus resulting in high false-positive prediction. As a result, accurate prediction of suicide and suicide attempts remains elusive (Fowler, 2012). Although risk factors and measures rarely provide consistent evidence of efficient diagnostic tests and predictability, experts generally agree that a multidimensional assessment incorporating the best-known suicidal risk and protective factors is the most reasonable course of action. This includes cultural competency and inclusion of factors that are specific to the individual's cultural experience. While prediction is highly unlikely, clinicians are nonetheless responsible for assessing suicide risk, and for providing treatment to decrease risk (APA, 2003). At the same time clinicians must work to enhance the therapeutic alliance by negotiating a collaborative approach to understanding why thoughts of suicide are so compelling (Jobes, Comtois, Brenner, & Gutierrez,

2011). Therefore, the overarching goal of any assessment of suicide risk should be conducted within a therapeutic frame in which collaboration and negotiation of role responsibilities are clearly articulated (Plakun, 1994).

There are various ways to assess for suicidality, such as screening, or detection, methods or full suicide assessments that are more comprehensive involving interviews, follow-up questions, etc. Detection Instruments are instruments that are used for identifying either the presence or absence of current and/or past suicidal behaviors or the degree of suicidality. These instruments can be used in studies describing the phenomenology of suicidal behaviors including their contextual factors, precipitants, and course, or estimating the prevalence of suicidal behaviors. Detection instruments are different from instruments that are used to estimate “risk” or “propensity” for suicidal behaviors. These latter instruments often assess constructs thought to be related to risk for suicidality such as hopelessness or reasons for living, and may or may not include questions about past or current suicidality.

Well-known screening inventories by Aaron Beck, founder of CBT, involve the Beck Depression Inventory for Youth and Beck Hopelessness Scale. Beck later developed the Scale for Suicide Ideation, the Suicide Intent Scale, and the Lethality Scales. The Scale for Suicide Ideation (SSI), which has been used in several studies to measure the intensity, duration, and specificity of psychiatric patients' plans and wishes to commit suicide, which all fall under the concept of suicidal ideation (Beck, Brown, & Steer, 1989). As discussed earlier regarding the tendency for assessments to over-detect, this test also tends to result in false-positives of suicide ideation. However, this is still a great conservative method for rapidly identifying potentially self-destructive cognitions. It should be noted, however, that while this does provide immediate results and can be used in crisis situations, the SSI should not replace the valuable information

that is obtained through clinical interviewing. Instead, the self-report version of the SSI represents another tool for the multi-method assessment of suicide ideation (Beck, Steer, & Ranieri, 1988).

Derived from data and recommendations from the American Psychiatric Association Practice Guidelines (2003), the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) is a comprehensive and efficient assessment strategy that partially overcomes the limitations of single risk factors by including recent stressful life events and current patterns of ideation and motivation for suicide, while providing the necessary counterweight of protective factors that may mitigate the likelihood of suicidal behavior in some individuals. Clinicians working with high-risk individuals are guided through the following steps: (a) identifying relevant risk factors, which can be later applied as goals for treatment, (b) identifying their protective factors, (c) administering an assessment interview including current suicidal thoughts, plans, behavior, and intent, (d) determining level of risk and select interventions to reduce risk, and (e) documenting the assessment of risk, the rationale for the chosen interventions, and follow-up after assessment and interventions (Fowler, 2012). This is especially important when developing a culturally-tailored version of this because it clearly defines the targets and goal as well as monitors the efficacy of the interventions throughout the treatment process.

For adolescents, there is an additional wide range of screening instruments that have been empirically-researched and are easily accessible (on their respective websites) to be used by mental health professionals as part of a full comprehensive assessment for suicidality for adolescents. These includes instruments that directly ask questions related to suicide, or other instruments such as diagnostic screenings for depression that can potentially be a protective factor. Examples include, but are not limited to, the Adolescent Suicide Interview (ASI), Child

Suicide Potential Scales (CSPS), Evaluation of Suicide Risk Among Adolescents and Imminent Danger Assessment (ESRAIDA), and Suicidal Behaviors Interview (SBI). There is a very good resource that can be helpful for mental health professionals to familiarize themselves with these instruments through the Suicide Prevention Resource Center. Due to the easy accessibility, simple use, and thorough information essential to treating suicidal adolescents, the link to the website will be provided in this manual. Regardless of the instrument a mental health professional chooses, The American Pediatric Association Committee on Adolescence (2001) recommended professionals “should be comfortable screening for suicide and mood disorders by asking about emotional difficulties, identifying lack of developmental progress, and estimating level of distress, impairment of functioning, and level of danger to self and others” (p.31). They suggest that the best way to assess for suicidal ideation is by directly asking or screening via self-report and that self-administered scales can be useful for screening, because adolescents may disclose information about suicidality in self-report that they deny in person and that adolescents who endorse suicidality on a scale should always be assessed clinically. It also must be again emphasized that “although suicide assessment scales have been developed for research purposes, they lack the predictive validity necessary for use in routine clinical practice” (The American Psychiatric Association Work Group on Suicidal Behaviors, 2006, p. 10). Therefore, the key highlight throughout this part of the intervention is that suicide assessment scales may be used as aids to suicide assessment but should not be used as predictive instruments or as substitutes for a thorough clinical evaluation.

**Developmental nuances.** As each client’s symptoms are conceptualized, interventions should be considered within the client’s appropriate developmental level. Suicidal behaviors have a variety of presentations and can impact individuals develop across the lifespan differently

(Daniel & Goldston, 2009). From a developmental theory, adolescents process information and respond to their environments in ways that may increase their risk for suicidal behaviors that other age groups may not express (Goldston et al, 2008). For example, adolescents are more likely to behave impulsively to emotionally triggering situations and may focus on proximal consequences of behavior, or the immediate outcome, rather than considering long-term consequences (Daniel & Goldston, 2009). The context, or stressors, of which adolescent suicidal behavior occurs can also be different from other age groups. This includes “family conflict, strivings for autonomy, academic and disciplinary difficulties, or disruptions in peer relationships that are increasing in importance as youth get older” (Goldston et al., 2008, p. 254). With the combination of stressors and impulsivity, adolescents can respond in potentially harmful ways, including nonlethal suicidal behavior. According to the Centers for Disease Control and Prevention (2012), nonlethal suicidal behaviors is a big public health concern due to the high number of suicidal attempts and child psychiatric emergency room visits (National Institute of Health, 2009). As a result, nonlethal suicidal behaviors are one of the best predictors of future attempts and deaths by suicide for adolescents (Joiner, Brown, & Wingate, 2005) and should be included when assessing clients for risk. In sum, two factors need to be considered when considering the developmental level of adolescents and adjusting areas of focus in treatment: the first is to consider the high impulsivity and high rate of suicidal behaviors within this age group. The second is that interventions must also consider the context of suicidal behaviors, such as family, school, and peer issues.

**Need for engagement.** Given the existing stigmas related to suicide and mental health, it is not surprising that suicidal individuals are often ambivalent about seeking treatment. Studies such as the ones by Rotheram-Borus, Piacentini, Rossem, Graae, Cantwell, et al. (2000) and

Spirito et al. (2003) highlight how brief interventions can resolve this issue and increase participation with suicidal clients. As previously explored for barriers to treatment for Latino/a families of suicidal adolescents, this issue is especially true and essential in implementing when both assessing and applying intervention for adolescents. This can happen for a number of reasons. For example, they may “experience embarrassment associated with participating in treatment, be uncomfortable discussing past suicidal crises or prevention of future difficulties, or may believe that a suicidal crisis does not recur” (Goldston et al., 2008, p. 18). From a developmental lens, they may not participate out of fear of being ostracized from peer groups (Daniel & Goldston, 2009). Parent involvement can also impact their willingness to engage. Adolescents may not feel comfortable disclosing their feelings to their parents; conversely, parents may be reluctant for their child to participate in treatment out of fear something is wrong with their child. Parents may reinforce tendencies toward dropping out of therapy by minimizing the seriousness of the adolescent’s suicidal behaviors or avoiding discussions about it at all (Daniel & Goldston, 2009). Therefore, there needs to be an effort on the part of the clinician to facilitate and motivate interest and engagement for both the suicidal adolescent and their parents or guardians. During the assessment process, this is an invaluable opportunity to begin to develop rapport and trust with the client and his/her family to increase the likelihood that they will complete full treatment.

To do this, some studies have shown some strategies that can assist the clinician in increasing engagement and facilitating trust. For example, brief Motivational Enhancement Therapy (MET) approaches have been shown to “increase readiness to change and commitment to participation in treatment for adolescents with substance use issues” (Monti, Barnett, O’Leary & Colby, 2001, p. 174). MET-based approaches can also assist suicidal adolescents because it

encourages them to be reflective in a non-confrontational manner. Demonstrating that the adolescent is not being judged negatively for their suicidal thoughts can make them feel validated for their experience (Monti et al., 2001). In turn, this can also progress to a stage of change in recognizing the need help and being committed to seek appropriate guidance to change their situation. Moreover, such approaches might help resolve ambivalence regarding the need to be in treatment or the need to make changes in the life circumstances in which the suicide attempt occurred, and may be useful in eliciting directions for treatment directly from the adolescent, and thus, more effectively establishing commitment to change. MET emphasizes the importance of a strong therapeutic alliance needed to facilitate trust, motivation, and commitment on the part of the ambivalent adolescent. In this regard, a study by Karver et al. (2008) found that there was a strong relationship between therapist alliance with the adolescent and adolescent involvement in treatment. The longer their commitment and participation, the more their depressive symptoms decreased. The findings highlight the importance of the therapist-client relationship in maintaining motivation and involvement in treatment, and the need to be especially sensitive to the emotional state of adolescents who have made suicide attempts.

### **CBT-based Interventions**

Based on the analysis of all interventions currently provided, the majority of interventions are primarily based on CBT foundations, including conceptualizations, assessments, and interventions. In recent years, several empirically-supported therapies to prevent suicide have been developed based on cognitive-behavioral techniques. These interventions include, but are not limited to, Cognitive Therapy (CT), Dialectical Behavior Therapy (DBT), and Cognitive Behavior Therapy for Suicide Prevention (CBT-SP). Each of



these interventions provides unique techniques targeted to reduce suicidal behavior and other forms of self-injury. Although the evidence base for DBT and CT are strongest, all of these interventions have shown promise as effective strategies for suicide prevention. In this section, an overview is provided for CT, DBT, CBT-SP and MBCT-S, with special focus on the theoretical framework, treatment approach and empirical support.

At its most basic level, the cognitive-behavioral model of suicidality, specifically, asserts reciprocal determinism between the environment and person. It is here that an individual's experiences are not linear events, but rather they exist within a dynamic context where the person and environment have a dual influence and interact with each other across many domains. David Rudd applies Aaron Beck's 10 axioms of cognitive theory to suicidality to develop the suicidal belief system, which includes the suicidal mode, cognitive triad, and associated conditional assumptions. Suicidality is a secondary consequence of maladaptive thoughts constructed by the cognitive triad: the self, the environment, and the future. The way this interactive relationship manifests varies with each individual; however, a common characteristic in the suicidal belief system is pervasive hopelessness (e.g., "My life is hopeless."). Core beliefs that stem from hopelessness are helplessness (e.g., "I can't do anything about my problems."), feeling unlovable ("I am worthless."), and poor distress tolerance ("I can't stand feeling this way anymore.") (Brown, Beck, Steer, Grisham, 2000). These distorted, or faulty, thoughts increase a person's vulnerability to suicidality. Internal and external triggers activate an individual's orienting schema (automatic thoughts) and results in activating the suicidal mode. Those who experience chronic suicidality are more susceptible to an array of triggers of the suicidal mode because of their lower activation thresholds. The affective system is distinguished by a mixture of negative emotions, or emotional dysphoria, such as anxiety, guilt, sadness, and anger. The behavioral

system includes an impulse to die, preparatory behaviors, practicing, and planning (Rudd, 2000). As various methods and strategies that are based under this CBT framework are evaluated, understanding how these interventions conceptualize patients is key in fully understanding the approach and efficacy.

**Cognitive-Behavioral Therapy for Suicide Prevention (CBT-SP).** One of the most widely available interventions available for adolescents is a manual-based form of psychotherapy for adolescents who recently attempted suicide known as Cognitive Behavior Therapy Suicide Prevention (CBT-SP). The focus of this intervention takes a risk reduction and relapse prevention approach and is aimed expressively at reducing risk for future suicidal behaviors in suicidal adolescents (Stanly et al., 2009). This treatment was developed in the context of a multisite study, Treatment of Adolescent Suicide Attempters, designed to prevent reoccurrence of suicide attempts in suicidal adolescents with depression. Although CBT-SP was implemented with suicide attempters, the theoretical approach and strategies may also apply to adolescents who experience episodes of acute suicidal ideation (as opposed to chronic unremitting ideation) in which precipitants can be identified. The primary goals of this intervention are to reduce suicidal risk factors, enhance coping, and to prevent suicidal behavior. Adolescents who make suicide attempts, or who have acute or persistent suicidal ideation, typically have multiple psychiatric and environmental problems (Bridge, Goldstein, & Brent, 2006). CBT-SP focuses on developing coping skills to assist the client in rethinking and redirecting behaviors when in a suicidal crisis. Family sessions with parents or caregivers are also part of the CBT-SP approach to reinforce learned coping strategies and generalize them at home. The CBT-SP consists of acute and continuation phases, both of which are generally completed within 6 months. The acute phase of CBT-SP ranges from 12 to 16 weekly sessions and of mostly individual sessions,

although family “check-ins” can also be conducted during this time. Interventions conducted during this phase include chain analysis, safety planning, and addressing reasons for living, and building hope.

The CBT-SP is based on a stress-diathesis model of suicidal behavior (van Heeringen, 2012). Within this model, the diathesis for suicidal behavior “includes a combination of factors, such as sex, religion, familial and genetic components, childhood experiences, and psychosocial support system” (Stanley et al, 2009, p. 1007). Some of these experiences or events can become stressors that trigger suicidal behavior in the context of an individual who possesses the diathesis. An adolescent who exhibits coping deficits can be more vulnerable to engaging in harmful behaviors in response to stressors. These deficits can include “the inability to regulate emotions, the inability to resolve problems, the inability to tolerate distress, and the inability to address negative thoughts or beliefs such as hopelessness or worthlessness” (Stanley et al., 2009, p. 1008). To determine these antecedents or stressors, a combination of developing a detailed chain analysis and identifying maladaptive behaviors are used. Individual and family treatment strategies are then selected based on their relevance from the perspective of the therapist, patient, and family (Stanley et al., 2009). CBT-SP treatment includes various CBT-based strategies including cognitive restructuring, identifying and evaluating automatic thoughts, emotion regulation, emotions thermometer, index cue cards, mindfulness, opposite action, behavioral activation and problem-solving strategies (Linehan, 1993).

**Problem-Solving Therapy (PST).** A wide variety of research findings indicate problem-solving deficits play a key role in the development and maintenance of depression and suicidal behavior. Deficits in problem-solving ability were shown to be an important predisposing factor for the development of depression (Priester & Clum, 1993a) and suicidal behavior (Pollock &

Williams, 2004). Recently, Speckens and Hawton (2005) reviewed the studies investigating the relationship between problem solving and suicidal behavior in young people. They concluded that ineffective problem-solving increases a youth's vulnerability to engaging in suicidal behaviors. Thus, one can presume that a problem-solving approach is an important intervention strategy for the treatment of depression and suicide risk in young people. In line with this, problem solving was identified as a prevention strategy for adolescent emotional problems (Spence et al., 2003). Youth, especially at this developmental level, need effective coping strategies or skills in order to gain resilience against multiple domain changes/challenges. Problem solving is an important life skill for coping and tackling with life difficulties and challenges during these stages of life.

Empirical evidence suggests that problem-solving therapy (PST) is an effective treatment for depression (Biggam & Power, 1999) and suicidal problems in young adults. PST, like most manualized treatments, are CBT based and time limited. It typically lasts 6 weeks, and patients meet with their clinician once a week. The manual includes six sessions of PST that correspond to the six stages of problem solving: Session 1. Definition of problems; Session 2. Goal setting; Session 3. Generating alternative solutions; Session 4. Decision making; Session 5. Solution implementation; and Session 6. Assessment and verification (Eskin, Ertekin, & Demir, 2008).

Malouff, Thorsteinsson, and Schutte (2007) conducted a meta-analysis of 31 studies involving mostly adult participants ( $n = 2,895$ ) to explore the efficacy of PST. They showed that PST was significantly more effective than no treatment. More specifically, another study by Verduyn, Rogers, and Wood (2009) tested the efficacy of problem-solving therapy in treating depression and suicide potential in adolescents and young adults. Participants in the problem-solving condition perceived their therapeutic alliance as being highly satisfactory. Further, the

results indicated that PST is an effective and acceptable treatment method for emotional problems in adolescents and young adults.

**Culturally-tailored CBT interventions for Latinos/as.** While still very limited, there is some literature that is beginning to emerge that is starting to develop integrated psychotherapy models to better treat Latino/a patients. The acquisition of cultural knowledge pertaining to specific groups is perhaps one of the most discussed dimensions of cultural competency (Interian & Diaz-Martinez, 2007). This skill set of cultural knowledge involves “understanding the beliefs, practices, and values of specific racial/ethnic groups. It further involves the social context in which clients’ problems occur” (Interian & Diaz-Martinez, 2007, p. 91). There are currently three articles that have specifically addressed this cultural factor when considering adapted interventions for Latino/a youth and their related issues.

Feminist theory was found to apply to themes that arise for Latina youth specifically, as they are at the highest risk for suicidal behaviors. The guiding principles of feminist theory include themes of empowerment and raising awareness in understanding how external social constructs promote gender oppression (Kushner & Murrow, 2003). The treating clinician works from a strength-based position, validating women’s life experiences and internal states, reinforcing assertive behaviors, and encouraging self-acceptance. The non-pathological stance toward women provides an environment that helps to heal from past traumas, advances personal transformation, and encourages social change outside the therapy room. Multiracial feminism appears to integrate multiculturalism with feminism by looking at the interrelation between two (Arellano & Ayala-Alcantar, 2004). For example, a Latina may experience a different level of power in a social context with friends or at church than compared to her employment as an administrative assistant in a White dominated company. Multiracial feminism stresses the

importance of identifying contexts and disputes the universal experience of womanhood by acknowledging that one's experience is influenced by external and internal realities (Arellano & Ayala-Alcantar, 2004). As described by Fodor (1993), feminist and cognitive-behavioral therapies have similarities which "allow for integration such as maladaptive behavior being understood as learned and formed by influences in the milieu" (p. 221). The content of one's thinking is explored, challenged, and eventually modified. Further, emphasis is placed that the client has control of their own improvement or changes in behavior, thus empowering themselves.

The second article highlights the cultural value of familismo. Rossello and Bernal (2005) adapted CBT to include families for Puerto Rican adolescents with depression. Doing so "provided opportunities for parents to better understand their adolescent's socioemotional needs within the perspective of their cultural expectations and the context in which their child was developing" (Goldston et al, 2008, p. 30). The study found that this adaption did reduce depressive symptoms among the adolescents. What has been frequently discussed thus far is the centrality of the family system within the Latino/a. In this regard, a cost-effective means of engaging parents can have a huge impact in reducing the Latino/a adolescent's suicidal behaviors in the future. This study encourages and provides ideas of how clinicians can further adapt and increase their cultural competence, such as reviewing recorded sessions or attending training programs.

Finally, the last article was a recent one conducted by Dueweke and Bridges (2016) who examined how psychoeducation (i.e. passing out brochures) impacts stigma and help-seeking behaviors of Latino/a immigrants. Their results found that psychoeducation increased knowledge and literacy about suicide, but it did not change the pre-existing stigmas participants held nor did

it change their help-seeking behaviors. One of the hypotheses for this surprising result is that stigmas are deeply rooted into a person's core beliefs and culture. Providing a brochure can be helpful in increasing education, but is not sufficient in changing these attitudes and requires more direct intervention. Even with these opportunities to discuss their beliefs about mental health can be more effective, the goal is not necessarily to change their cultural beliefs, but to encourage them to seek help that will ultimately reduce the symptoms impacting them.

**Systematic reviews.** A number of recent studies have conducted systemic reviews of multiple cognitive behavior therapy for adolescent suicide to determine their true efficacy. While the many studies that have already been conducted for specific therapies, there still remains and inconsistent and limited clear answer as to whether they truly address the symptom they are trying to change. Unfortunately, over half (63%) did not describe their methodology or evidence explicitly, so any attempts to replicate those studies becomes a challenge. The end result is contradictory conclusions that do not provide any further insight as to the true effectiveness of these strategies. Some authors have found the evidence in support of the efficacy of psychosocial treatments in preventing the recurrence of suicidal and self-harm behaviors in adolescents to be equivocal (Bursztein & Apter, 2009), whereas others have concluded that psychotherapies centered on support strategies (Brent et al., 2013) or on core emotion regulation skills hold great promise. These early qualitative and quantitative literature reviews suggest that, at best, psychosocial treatments, including those applying a CBT approach, have limited efficacy in reducing suicidal and self-harm behaviors in adolescents. Twelve published studies were evaluated by Daniel and Goldston (2009) based on their statistical significance. They concluded “that interventions for suicidal youth have been in general more successful at affecting aspects of service utilization and delivery (e.g., compliance with medical recommendations, aftercare

utilization, reduced hospitalization, decreased time to outpatient appointments) than in reducing rates of suicide attempts per se” (p. 259). One of the issues that arises for Latino/a adolescent teens is their ambivalence toward participating in mental health services; however, these interventions show promise that it can help facilitate the connection between the adolescent and therapy as a stepping stone towards further commitments to change. In addition, Wasserman and colleagues (2012), who also reviewed the literature on the effectiveness of psychosocial treatments, have contended that available empirical findings support the efficacy of CBT interventions in preventing the recurrence of suicidal and self-harm behaviors in all clinical populations (i.e., including children and adolescents). Goldston et al. (2015) examined this trend by evaluating the behavior and suicidal risk as adolescents with a history of attempts grow into adulthood. They found that the risk, frequency of attempts, and severity increase as the adolescent develops into adulthood. Their findings highlight the strong need for “relapse prevention interventions that interrupt the cycle of escalating suicidal behavior among individuals who already have made attempts” (p. 254). Conclusions of previous scholars’ works have to thus be put in the context of procedural, conceptual, and quantitative issues forwarded.

When looking at the efficacy of an intervention, evaluating how clients cope after treatment is completed is also important to explore. When looking at follow-ups with clients who received a form of CBT-based intervention for suicidal and self-harming behaviors, however, various results occurred. Corcoran, Dattalo, Crowley, Brown, and Grindle (2011) conducted a systematic review of interventions during posttest phase. They found that immediately following intervention, participants were only slightly less likely to engage in suicidal or self-harming behaviors. This is in contrast with their finding that longer after treatment (approximately one year), participants were actually slightly *more* likely to have suicidal or self-harming ideation.



The authors were not able to provide a clear hypothesis for this outcome, but it can be considered that the long-term effect of these interventions are limited. To address this shortcoming, a possible solution can include providing “booster” or follow-up sessions following treatment. Studies exploring this are limited, but it is important for the therapist to note that even after a crisis has passed for the adolescent, follow-up and reassessment is very key to reduce the risk of suicidal behaviors returning.

Because interventions crossed the gamut and included cognitive- behavioral interventions, family therapy, and myriad other programs, it is difficult to argue that developing additional programs to treat adolescent suicidality is the answer (Corcoran et al., 2011). Indeed, clinically significant improvements in suicidal and self-harm behaviors were more likely with interventions designed specifically to alter suicidal and self-harm behaviors. In this regard, as suggested by Spirito, Esposito-Smythers, Wolff, and Uhl (2011), treatment should target suicidal and self-harm behaviors directly for maximum benefit and that building coping skills and boosting affect regulation in adolescents are promising avenues for treatment. The development of effective coping and emotion-regulation skills should, as studies have already shown, not only result in a significant decrease in suicidal and self-harm behaviors among adolescents in treatment but also provide the means to choose constructive alternatives for action in the face of adversity. What is more, these skills would be useful throughout adolescence and into adulthood.

**Interpersonal Psychotherapy.** As previously discussed, suicidal clients often have a negative view of themselves resulting in internal attributions (self-blame) when aversive events occur and external attributions when positive events occur (Freeman & Reinecke, 1993). This conceptualization of suicidal ideation as faulty thinking allows for the development of a set of practical techniques aimed at encouraging clients to reassess the underlying beliefs responsible

for self-defeating automatic thoughts. CBT typically starts by identifying the motives for suicide and training clients to question the evidence for negative automatic thoughts when they arise. Clients are taught self-instruction to reduce ruminating about failures when such thoughts arise and to practice more positive, adaptive automatic thoughts and behaviors. Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) adds an additional step where the focus is on the suicidal clients' interpersonal relationships. It is a brief form of therapy (12 weeks) developed by Klerman, Weissman, Rounsaville, and Cevron (1984) that was adapted from a format originally designed for adults. It addresses issues more commonly related to the adolescent's developmental issues, including parent-child stress, authority in relationship to parents, development of interpersonal relationship and identity, and peer pressure. Studies conducted to test the efficacy found that adolescents who received IPT-A reported significantly greater decreases in depressive symptoms and greater improvement in social functioning and social problem-solving skills (Young, Mufson, & Davies, 2006). IPT-A incorporates three key features: family-involvement, brief therapy, and problem-solving skills based on social interaction; these features are mainly used to target depressive symptoms, but they also highlight how effective they can be in reducing suicidal risk. Incorporating these three features in interventions for suicide can be helpful in addresses the strong challenge adolescents with under-developed problem-solving skills face.

### **Family Therapy**

Similar to interpersonal therapy, family counseling is an important approach to suicide prevention because systemic factors, such as family interaction patterns are known to play an important role in precipitation and preventing suicide. Family counseling is equally applicable to families with children at risk for suicide (McLean & Taylor, 1994). CBT-based family therapy

has been shown to have merit when working with suicidal individuals, and family counselors using CBT methods help families to develop better methods of interpersonal functioning and to correct dysfunctional thinking.

Various programs based on CBT that include family therapy practices have been developed over the recent years. Three programs have been studied to determine their effectiveness in reducing suicidality. The first is a program specifically designed for parents called Parenting Adolescents: A Creative Experience (PACE) and was trialed throughout Australia among parents of 13-year-old children (Jenkin & Bretherton, 1994). The program focused on building parenting skills, improving parents' self-esteem and confidence, and decreasing parent depression. Studies support that it improved family attachment and reduced risk factors associate with suicide, including self-harm and substance abuse (Hawton, Sanders, & O'Conner, 2012). The second is called the SAFETY Program, which is a brief intervention designed for integration with emergency services for suicide-attempting youths. This program is also rooted in the CBT model, it provides individual and parent sessions over a 12-week period. The treatment emphasizes enhancing protective supports within social systems (family, peers, community) and includes one therapist for the youth and another focusing on the family. Sessions include a first component where youths work with the youth therapist while parents work with the parent therapist, and a second family component where all come together to practice skills identified as critical in the pathway for preventing repeat suicide attempts. It was primarily developed to improve the likelihood that adolescents who received emergency treatment follow-up with treatment. Asarnow, Berk, Hughes, and Anderson (2015) administered a treatment trial and results support feasibility, safety, and suggest treatment benefits. Youths receiving the SAFETY treatment showed statistically significant improvements in suicide

behavior, depression, hopelessness, suicidal ideation, and social adjustment. Their parents showed statistically significant declines in depressive symptoms. The third intervention is called the Youth-Nominated Support Team (YST) for previously hospitalized adolescents. Developed by King and colleagues (2006), YST focused on connecting the youth with a support system by regular contact with their support members, and providing psychoeducation and training was provided to the support team (Daniel & Goldston, 2009). For more than half of the participants, adolescents nominated their parent or caregiver as a member of their support team. YST also allowed inclusion of other significant others including “individuals in the schools, extended family, or religious community” (Daniel & Goldston, 2009). An interesting observation of the King et al. study (2006) is that while YST did not result in significantly reduced suicide attempts, it did decrease the severity of suicide ideations for girls. One hypothesis is that YST encourages support and encouraging responses from parents, which impacts risk for suicide attempts for Latinas. YST, therefore, highlights the essential step in including and providing training for parents so they can provide appropriate support for suicidal adolescents, as improve the parent-child relationship.

The PACE, SAFETY, and YST programs share similarities in that the emphasis is placed on not only family involvement, but providing treatment to the family members themselves. They are integrated as an essential part of these approaches, and not a secondary or optional component as more traditional and individual focused therapies would be. This is consistent with the research related to suicidal adolescents that demonstrates the increased need for finding supports for this population, as isolation increase their risk. With Latino/a adolescents, specifically, the component of familismo is an important part of their culture, which shows that family therapy may show promise in future research when applied to this particular community.

Other approaches related to family therapy have been studied in addition to the prior two discussed, but provided home-based services instead. Huey and colleagues (2004) studied a brief and home-based form of therapy called Multisystemic Family Therapy (MST). MST's goal is to "improve parenting ability and communication with youths, to promote prosocial activity among youths, and to address systemic factors that may be contributing to difficulties" (Huey & Polo, 2008, p. 284). Studies that evaluated MST found a decrease in the occurrence of youth-reported suicide attempts, but not severity of suicide ideation, over the one-year follow-up (Huey et al., 2004). The intervention did not result in differences in severity of suicide ideation or in rates of suicide attempts over the follow-up. Overall, with these particular interventions, it is somewhat unclear of its true efficacy overall, but shows some improvement with certain populations (i.e. non-depressed patients versus depressed patients). It highlights the lack of research that focuses on these diversities to reveal what can contribute to them being effective and potential limitations. Given that for Latino/a adolescents, access to care is a huge factor in risk in suicidality. It further highlights the needs for additional research and development of home-based interventions.

The overall message from many of these studies is that family inclusion and support is vital to the success of treatment with suicidal youth (Logan & King, 2001). This is for a number of reasons. One reason is that parents and caregivers must help facilitate linking their children to treatment. This also requires parental consent for adolescents to participate in therapy. Additionally, parents and caregivers play a crucial role in maintaining a viable safety plan and monitoring the adolescent to ensure they continue to engage in safe behaviors (Daniel & Goldston, 2009). A secondary gain from this is that increased communication and positive interactions between the parent and child can improve the relationship between them. As

described in Linehan's (1993) developmental model, "individuals who do not feel validated (e.g. in an invalidating environment) particularly if they are temperamentally prone to emotion dysregulation, may be more likely to escalate problem behaviors such as recurrent suicidal behavior" (p. 13). With the proper training and psychoeducation, the adolescent can feel understood and validated by a parent who now knows how to support them through a suicidal crisis. Adolescents can be more willing to share and disclose, which in turn decreases their need to engage in suicidal behaviors. Hence, approaches that help adolescents develop ways of eliciting validation and non-judgmental responses from others or help the parents of adolescents to provide such validation can be useful.

**DBT-based interventions.**

As stated in the Literature Review chapter, Dialectical behavior therapy (DBT) was originally developed by Marsha Linehan to address complex and severe symptoms related to Borderline Personality Disorder. Based on the biosocial theory, DBT views emotion dysregulation as the primary cause of symptoms of Borderline Personality Disorder, including suicidal behaviors and NSSIs. An adolescent's repeated exposure to an invalidating environment can worsen the ability to regulate emotions following stressful events. Invalidation environments for adolescents often include conflicts in close relationships, especially the parent-child relationship. Therefore, DBT contains strategies for reducing self-harm, therapy interfering behaviors, and quality of life interfering behaviors, as well as strategies to increase the use of life skills that are compatible with a life worth living. Since its development, DBT has been adapted to target the specific symptoms of self-harming behaviors and suicidality (Chanen, Jovev, & Jackson 2007), as both strongly increase risk of suicide attempts. DBT for adolescents, or DBT-A, includes behavior-focused therapies, family therapy, collateral sessions with parents, and

telephone skills coaching for parents, as needed (Miller, Rathus, DuBose, Dexter-Mazza, & GoldKlang, 2007). Parental expectations and psychoeducation are important targets for intervention and emphasized in DBT-A for adolescents (Miller et al., 2007). Parents often lack sufficient information about psychopathology and thus attribute the teen's negative behaviors to willfulness or defiance, rather than mental health problems, which leaves parents with unreasonably high expectations for the teen (Kennard et al., 2009). Inherent in the principles of DBT is a nonjudgmental perspective of the youth's behavior, and parents are taught that their children are doing the best they can (Miller et al., 2007). Emerging studies (e.g. Mehlum et al., 2016), found that DBT-A is associated with greater long-term reduction in self-harm and more rapid clinical improvements in suicidal ideation, depression, and borderline symptoms than is usual care.

The corresponding assessment inventory, Reasons for Living-Adolescents (RFL-A), was developed as part of the DBT-A approach. The RFL-A is a 32-item self-report inventory that asks various questions to get a better glimpse of the adolescent's adaptive beliefs and attitudes against suicide (Osman et al., 1998). Studies have found its usefulness in assessing based on DBT theory, however, because it is a set number of items with a pre-arranged method of response, it can be limiting in incorporating cultural factors that can affect the teen's attitudes about suicide (Osman et al., 1998).

### **Means Restriction**

A quickly growing body of research is acknowledging that limiting access to means significantly reduces suicidal risk. A suicidal person's access to highly lethal means, or methods, of suicide can be reduced through (a) physically impeding access (e.g., using gun locks and bridge barriers); (b) reducing the lethality or toxicity of a given method (e.g., reducing carbon

monoxide [CO] content of motor vehicle exhaust); or (c) reducing *cognitive access*, that is, reducing a particular method's appeal or cognitive salience (e.g., discouraging media coverage of an emerging suicide method).

Reducing access to lethal means saves lives when people who cannot readily obtain a highly lethal method either attempt with a method less likely to prove fatal or do not attempt at all. The rationale rests on four well-established observations. First, many suicidal crises are short-lived. A survey of people who had seriously considered suicide in the past year found that for about 30%, the suicidal period lasted under an hour (Barber & Miller, 2014). Surveys of attempters have found that the interval between deciding on suicide and actually attempting was 10 minutes or less for 24%–74% of attempters (with the lower end of the range reported by a study of those nearly dying in their attempt) (Barber & Miller, 2014).

Second, the method people use in suicidal acts depends, to a non-trivial extent, on its ready availability. Third, the proportion of attempts that result in death (case fatality ratio) varies dramatically across methods, ranging from a high of 85%–90% for firearms to a low of 1%–2% for the methods most commonly used in attempts—medication overdoses and sharp instrument wounds (Barber & Miller, 2014). The lethality of the method readily available during a suicidal crisis therefore plays an important role in whether the person survives an attempt; intent matters, but means also matter.

In the U.S., more suicides are completed with a firearm than by all other methods combined. About one in three homes contain firearms and 51% of all suicides involve firearms. Miller et al. (2007) have provided a review of U.S. firearm suicides. All U.S. case-control studies that have examined the issue have found that the risk of suicide is two- to five-fold higher in gun-owning homes for all household members, with relative risk being especially high for youth



and people without known psychopathology. The higher suicide risk is driven by a higher risk of firearm suicide, with no difference in non-gun suicides. Firearms have several characteristics that make them particularly suitable targets: They are the leading suicide method in the U.S. (approximately 19,000 deaths a year); they are the most lethal (substituted methods will be less likely to kill); they are both accessible and cognitively acceptable in U.S. culture; and an attempt with a gun once initiated cannot be reversed (unlike attempts with nearly every other method except jumping; Barber & Miller, 2014). This approach is especially promising for youth, whose firearm suicides typically involve a family member's gun. A small body of literature on parents of youth with psychiatric problems suggests that families who were counseled to reduce access to firearms and medications at home were more likely to do so than those not receiving such counseling.

### **Psychodynamic-Focused Psychotherapy**

Emerging evidence suggests that psychodynamic psychotherapy is effective in reducing suicidal behavior (Rossouw & Fonagy, 2012). Crucial to the treatment of suicidal adolescents is how to engage the patient in the therapeutic process and which techniques are most useful to initiate psychic change. Whitlock, Wyman, and Moore (2014), for example, showed that after a suicide attempt only about 50% of younger adolescents engaged in treatment lasting more than six sessions. The challenge for the 'active therapist' is how to show the suicidal adolescent patient that he/she is interested in his thoughts and feelings, no matter how uncomfortable these may appear, while at the same time being very careful to not act overtly intrusively with unhelpful parental transference. Adolescents appear particularly sensitive to these transference manifestations, which may trigger aversive reactions or negative therapeutic responses (Goldblatt, Briggs, Lindner, Schechter, & Ronningstam, 2015). Much like with CBT, the

importance of a strong therapist-client alliance is needed to provide effective treatment for suicidal youth. In a study of analytic outcome, Bush and Meehan (2011) associated a good fit between therapist and patient and positive therapeutic alliance with successful treatment: “a caring and emotionally engaged analyst who possessed positive relational and personality qualities, used supportive techniques in addition to classical techniques, and pursued therapeutic as well as analytic goals” (p. 377). Effective psychotherapy with suicidal adolescents can thus be thought of as developing through a strong therapeutic relationship.

To assist the therapist in this process, authors have found that conscience-sensitive assessment can help a clinician get closer to the heart of intrapsychic processes that either promote or protect against suicidal impulses. As defined by Dijksterhuis and Nordgren (2006), who explain the theory of unconscious thought, the conscience is a consciously accessible mental representation of a person’s sense of right and wrong and good and bad. Nurtured by moralizing experiences from infancy forward, a child goes through five stages of reorganizing this intrapsychic construct before the age of 18. The psychological domains of attachment, emotion, cognition (executive functioning), and volition each contribute to a personal conceptualization of conscience. This mental construct operates as a reference point in psychodynamic processing of moral issues. Lifetime adversities may stimulate or slow its development whereas psychopathology may interfere with its functioning (Dijksterhuis & Nordgren, 2006). The value that a person places on life is a matter of conscience. Galvan, Hare, Voss, Glover, and Casey (2007) explored three psychodynamic-based exercises that have been found to be clinically useful in treating suicidal adolescents. A case study where these exercises were applied to a specific patient was provided to demonstrate the efficacy of the exercises:

1. Moral genogram. Similar to a traditional genogram, the patient is asked to identify

people in her family with whom they have experienced the most emotional warmth and severe emotional conflict. They are then asked to identify the people who cared the most about their moral worth (affirmed their basic goodness) and those who had cared the least. Associated memories thoughts and feelings were encouraged (Galvin, Fletcher, Stilwell, & Jellinek, 2006). This exercise highlights the domain of conscience functioning known as moralization of attachment (Galvin et al., 2006). It is rooted in a bedrock value for human connectedness. Cumulative experiences of caring, empathy, and moral expectation with attachment figures create a security-empathy- mental representation within the child's conscience. Such experiences engender a sense of moral obligation between the child and caring family members.

2. Suicide Walk. The Suicide Walk elicits a patient's fantasies about the impact of an accomplished suicide on significant family members and friends. In addition to the moral attachment domain of conscience, this exercise taps into the domain of conscience known as moral volition (Stilwell et al., 1998). The bedrock values of moral volition are autonomy and willpower.
3. The Value Matrix. This exercise was designed to help a patient to analyze his or her motivation for complying with or negating value-laden mandates of conscience—personal set of “do's” and don'ts.” It allows the patient to evaluate their motivation to die and to live.

While the evidence to support the efficacy of these exercises is limited, it is included in this dissertation as it is one of the few resources that addresses conscience-related psychodynamic issues that support or protect against suicidality. Integrating other psychological

theories and orientations can increase the clinician's flexibility and ability to adapt therapy to best fit the needs of each individual client. For psychodynamic theory, the goal is to uncover conscience-related psychodynamic issues that support or protect against suicidality. These issues can then be highlighted in treatment planning.

### **Brief Therapy with Technology**

More recent literature is beginning to explore the use of technology as a way to incorporate brief therapy and improve accessibility for clients. Since the development of smart phones, there are a growing number of "apps" that clients can access to get additional support including meditation and breathing exercise, as well as completing CBT-based exercises. As of 2013, an estimated 78% of American youth have mobile devices, of whom 47% have a smartphone. Approximately 25% of all teens are "cell-mostly" Internet users, and this number is significantly higher in teens who own a smart phone (50%; Madden, Lenhart, Duggan, Cortesi, & Gasser, 2013). With the rapid growth of personal technology, there is an increasing demand for its utilization in the health care field. Mobile devices, and specifically smart phones, have the capacity to extend interventions through text messaging, mobile-ready web pages, and phone applications (Gaggioli & Riva, 2013). There is growing literature that supports the applicability of mobile phones to the field of mental health (Aboujaoude, Salame, & Naim, 2015). Many phone applications that are currently available address a wide number of diagnoses, including anxiety, depression, behavior modification, and so on. For suicide prevention specifically, a 2013 review article by Aguirre and colleagues, found a total of 27 pre-existing phone applications that were related to suicide prevention. Despite the number of available phone applications, there are few specific to suicide prevention and even fewer designed for children and adolescents. There is, however, a show of promise in improving access to care for families that have difficulties,

especially Latino/a families. Kennard et al. (2015) conducted a qualitative interview study to review children and parents' perspective of mobile apps to improve connectivity and follow-through with safety planning. All participants endorsed a phone application to improve accessibility and portability of the patient's safety plan. Teens and parents indicated a high degree of use and comfort with smartphones and phone apps. A personalized safety plan phone application would allow for greater availability of individualized and targeted skills.

### **Summary of Interventions**

Before summarizing the main highlights of current interventions, one observation that was made in this dissertation, as well as in other studies, found that many of these interventions are limited in areas of cultural and developmental levels. Most of these interventions have not focused on the diversities that exist within suicidal youths, but have developed more general or broad ideas of theories designed to apply to all adolescents. As has been noted, however, adolescent suicide attempters include a wide variety of personalities and belief systems. Much like using the general term of Hispanic or Latino/a, subcategories and cultures can become minimized or ignored altogether by these broader characteristics. For example, in a study by King et al. (2006), social support interventions showed to impact adolescent girls by reducing suicidal thoughts more than adolescent boys. Most of these interventions, have not explicitly acknowledged these developmental differences. Despite this limitation, the evidence of the efficacy of these interventions show promise that it can have some impact that is still very much needed for this population. There is also a strong need that when conducting a comprehensive assessment and building rapport, that it is not just the symptom that is being addressed, but the multitude of layers that contribute to why the individual is exhibiting that symptoms. Conceptualization and formulation of each case is an important step that can often be rushed

through to go straight to intervention. To be an effective therapist, especially when dealing with suicidality, being thorough and taking full ethical steps is essential in increasing the safety of the client as much as possible.

After considering factors that contributes to the individual's own processes related to his/her symptoms, appropriate interventions can then be applied. With the review of interventions done for this dissertation, many common themes arose that showed the most promise, potential, and evidence of efficacy. These common themes included the following: 1. Brief interventions for addressing crises were found to be much more effective. 2. Taking time to build strong connectedness and rapport with adolescent clients is an important step that should not be rushed through and is in itself an effective intervention. 3. Applying and taking a skills-building approach, including guidance in problem-solving strategies, improves the accessibility and reduces the impression of stigma or judgment of the adolescent's suicidal thoughts or behaviors. 4. Including family involvement is key for this population, which sends the larger picture that finding and adding elements of support for the client improves their safety. 5. Improving easy accessibility to treatment, especially during a crisis, is essential. Providing resources to crisis hotlines or smartphone apps have been effective strategies for this population in particular. 6. A growing research base shows that means reduction is one of the most effective interventions that can be applied. These themes are very common with the themes that also arose as protective factors for Latino/a adolescents. This shows promise that interventions for this population is moving towards the right direction, but needs to target the specific barriers that impact Latino/a adolescents.

### **Integration of Literature**

Now that all of the data have been reviewed, the next phase (Phase IV) integrated all of

the main points and themes to inform the content of the resource manual. In Table 1, a summary of all themes for both topics is provided side by side to visually see and compare how strategies can be adjusted to include issues that relate to much of the Latino/a population. The six activities developed for the manual is provided in Table 1 below to assist in connecting themes:

Table 1.

*Side by Side Summary of Themes in the Literature for Each Separate Topic*

Risk and Protective factors for Latino/a Adolescents	EBP intervention strategies
<ul style="list-style-type: none"> <li>• Cultural attitude towards Mental Health</li> <li>• Cultural Attitude towards Suicide</li> <li>• Help-Seeking Behaviors</li> <li>• Access to Care</li> <li>• Immigration, Assimilation, and Acculturation</li> <li>• Latinas</li> <li>• Cultural expression of distress</li> <li>• Discrimination</li> <li>• Religion</li> </ul>	<ul style="list-style-type: none"> <li>• Open-ended assessment</li> <li>• Engagement and developing strong rapport</li> <li>• In-person therapy</li> <li>• Home-based therapy</li> <li>• Brief Therapy (i.e. CBT-SP)</li> <li>• Problem-Solving skills and coping (i.e. PST and DBT)</li> <li>• Family inclusion in therapy</li> <li>• Strengthening interpersonal skills</li> <li>• Means Restriction</li> <li>• Technology Incorporation (i.e. iPhone apps)</li> </ul>

As previously stated, the length of the resource manual is approximately 10-15 pages and information is presented in both paragraph and bullet-point format for clarity and ease of use. The manual includes diagrams and tables related to the content to further encourage comprehension of the materials. This section explains the structure and incorporation of elements from phases II and III of the dissertation to plan out the development of the manual.

Before describing the manual, a detailed description of the purpose and intent of it must be explained for ethical purposes. Interventions described in this dissertation, and those that will ultimately be provided in the manual, are for mental health providers that already have competent training and understanding of proper suicidal assessment and safety management. To

describe in greater detail, the proper steps of treating suicidality, including assessment and intervention, is beyond the intent of this dissertation and professionals utilizing this manual should already have an advanced level of competence in assessing for suicidality. One resource that is easily accessible and available to professionals that details these steps based on APA standards is provided on their website. The link to that manual will be provided in the manual for professionals to use if needed. This manual is intended to be an extension of the professional's training to address cultural factors for a specific population. The manual being developed for the purposes of this dissertation will follow the guidelines provided under the APA manual of Assessment and Treatment of Patients with Suicidal Behaviors (2010):

These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be interpreted as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available (p. 5).

Similarly, this dissertation and the resulting manual are not meant to replace or remove essential steps when addressing suicidality.

**Section I: A brief introduction and psychoeducation.** Part of the responsibility of the mental health provider in addressing suicidality is to inform themselves of the current risks and factors that relate to them. This information can then be provided to the client and family as the provider finds appropriate. While a more passive form of psychoeducation (e.g. just providing information) may not be seen as changing help-seeking behaviors, active psychoeducation



(incorporated as part of the therapy), can improve this likelihood (Dueweke & Bridges, 2016).

The manual therefore includes a briefer description of the current statistics related to adolescent and adolescent Latino/a suicidality, including the points below:

- For adolescents the ranking of suicide increases significantly higher than the general population; suicide is the third leading cause for children ages 10-14 and the second leading cause for ages 15-24 (Center for Disease Control [CDC] WISQARS, 2015).
- The Center for Disease Control and Prevention revealed that each year in the United States, approximately 2,000 to 2,500 adolescents under the age of 20 complete suicide.
- 100-200 suicide attempts are made for every one completed suicide amongst this age group (Goldsmith et al., 2002).

This section also specifies who is to use the manual, which is any mental health professional who frequently treats Latino/a youth who may be at risk for suicidality. Just as there is a diverse range of adolescent clients, there is also a diverse range of professionals who treat them. Due to the high need for accessibility for both adolescents, especially adolescent Latino/a youth, limiting the range of qualified disciplines or types of competent professionals that can utilize this manual would be counterintuitive. Therefore, mental health providers with adequate training in ethical principles and competence in treating this population, can integrate information provided in this manual to their practice; types of professionals include psychologists, psychiatrists, psychology trainees, social workers, or License Marriage and Family Therapists (LMFTs). When treating a client with suicidal ideation or behaviors, it is always important that providers follow the ethical principles under the American Psychology Association (APA) or their respective professional field.

Finally, definitions of key terms including Latino/a, adolescence, and suicide are provided. These terms, especially, vary from study to study, and can potentially be interpreted and perceived differently from individual to individual. Therefore, to avoid confusion. The definitions are provided.

**Section II: Consideration of risk and protective factors for Latino/a youth.** A concise description of the current research exploring risk and protective factors for suicidal Latino/a youth is described in this section. More specifically, this section presents data from the literature about the risk-factors and identifying individuals who are at high-risk for having suicidal thoughts and/or intent. This will also include protective factors that are unique and/or can overlap with some of the stated risk factors that are important to consider when assessing and determining appropriate treatment interventions. These are detailed below, as provided in the Phase II part of the dissertation:

- Cultural attitude towards mental health. Inquiring about the cultural perceptions of mental health, especially among the family can impact how involved that individual and their support system can be in their treatment. Establishing strong rapport and trust can help build more positive attitudes toward seeking out professional help.
- Cultural attitude towards suicide. Inquiring about the individual and their culture's perception of suicide provides insight for the therapist and the client of what thoughts and hesitations around stigma might be limiting or encouraging their use of resources to their fullest potential.
- Help seeking behaviors. Much like cultural attitudes toward mental health, the mental health professional's increased awareness of patterns and tendencies of

where adolescents go to seek help is helpful in appropriately addressing treatment and correct psychoeducation.

- Access to care. Various studies have shown that access to mental health care is a noted challenge at times for various reasons, including transportation, lack of knowledge, or language barriers. This is particularly true for the parents and caregivers of adolescents. It therefore emphasizes the need in diversifying how mental health care is provided to best accommodate their needs, such as providing services at home, school, etc. At the very least, a greater effort is needed on the part of the provider to initiate and engage in a discussion with the adolescent and their family to address potential concerns and collaborating to problem-solve ways of addressing those barriers.
- Immigration, assimilation, and acculturation. There are many pieces and elements within the scope of impact that immigration and acculturation plays on families. Because of the complexity of these issues alone, it is imperative that mental health care professionals engage in some conversation with the adolescent to discuss how these issues may or may not impact them and contribute to their stress.
- Latinas. Awareness of the issues and higher risk of Latina adolescents is important when the client identifies as such. This not only is an important step when assessing for suicidality, but in asking questions about their experience as a Latina can validate their experience and provide a safer space as a result.
- Cultural expression of distress. Different cultures express and communicate their distress in various ways. Research commonly notes that somatic symptoms can

indicate the presence of psychological distress. Following evaluations from medical providers, inquiring about triggers or pain and prior forms of treatment can provide essential detail if their distress is related to psychological pain that is impacting their daily functioning.

- **Discrimination.** Given that research has found discrimination to predict self-esteem, and self-esteem to predict depressive symptoms, it is important to consider self-esteem as a mediator when examining the relation between discrimination and depression.
- **Religion.** Determining whether religion plays a factor in a person's likelihood to engage in self-destructive behaviors, such as substance use, has been explored. For suicide specifically, the data is very limited, but does show some possible effect in it, especially with Catholicism, changing the help-seeking behaviors of immigrant Latinos/as specifically. Discussing or incorporating traditionally Catholic beliefs, prayers, or groups can be beneficial in providing a positive safe space for adolescents and their families. Discussion of the role religion plays on the individual is encouraged.

**Section III: Interventions.** This section is the heart of the manual that will provide the mental health provider with common themes that arose after evaluating evidence-based strategies that show the most potential in effectively treating this population. These themes fall within three main stages of suicide intervention: 1. Assessment of Suicidality 2. Safety Planning and Treatment, and 3. Follow-Up and Reassessment of Risk.

The first stage is focused on assessment, while considering the cultural risk and protective factors for that individual. Asking specific questions, especially related to their

perception of death, suicide, and mental health, can not only help provide essential information for assessing risk to the therapist, but also begin to build trust and strong rapport. Developing good rapport with this population is shown to be essential in increasing the person's willingness to share candidly and will improve the likelihood that the individual will follow through with treatment. Research has shown that the client-therapist relationship is absolutely important for both adolescents and Latino/a populations. In addition, assessing for history of nonlethal suicidal behaviors or self-harm as it is a strong predictor for suicide in adolescents.

Using assessment scales are also useful tools to incorporate as part of the assessment stage. The majority of instruments that have been studied the most are primarily CBT-based self-report scales. A useful resource where therapists can familiarize themselves with current assessment instruments for adolescent suicide is provided by the Suicide Prevention Resource Center. The link is provided in the Resources section of the manual.

The second stage is Safety Planning and Treatment. The common themes that arose for this stage include the following:

- Brief interventions for addressing crises were found to be much more effective. Adolescents who seek treatment following suicidal behaviors tend to drop out of treatment earlier. Applying interventions that are brief not only better address the immediate crisis that is triggering those behaviors, but can improve the likelihood that adolescents will complete the entire therapy.
- Taking time to build strong connectedness and rapport with adolescent clients is an important step that should not be rushed through and is in itself an effective intervention.

- Applying and taking a skills-building approach, including guidance in problem-solving strategies, improves the accessibility and reduces the impression of stigma or judgment of the adolescent's suicidal thoughts or behaviors. Examples include CBT-SP and PST.
- Including family involvement is key for this population as it provides a support for the client improves their safety. While home-based family therapy shows mixed results, considering how to improve access to care is an important discussion to have when incorporating family and members for support.
- Improving easy accessibility to treatment, especially during a crisis, is essential. Providing resources to crisis hotlines or smartphone apps have been effective strategies for this population in particular.
- Growing research shows that means reduction is one of the most effective interventions. During the assessment phase, if a plan and means have been identified, part of the safety planning is to remove the individual's access to those means. Challenges with reducing certain means can arise, such as removing prescription medication for medical purposes. Discussing a plan with the client and family can be helpful in collaborating together to navigate around those challenges (e.g. give medication to a family member who can closely monitor dosage).
- Emerging research for Latino/a-focused therapies for suicidal adolescents is increasing. Certain characteristics of these interventions show potential and promise in their ability to reduce risk. These include themes of empowerment and family inclusion. Given the historical and societal context of oppression and

Latinos/as in the United States, empowerment is especially important in increasing for this community. Both of these themes should be considered and incorporated in therapy.

Six concrete interventions were developed based on these on strategies, with consideration of risk and protective factors of Latino/a adolescents. These interventions will be described and explained for therapists to utilize in their own practices when addressing suicidality with clients. Examples of these interventions are provided in the Appendix section.

1. Things to live for list (with supplemental cultural piece of protective factors). Inspired by the assessment inventory, Reasons for Living-Adolescents (RFL-A) based on the DBT perspective, a more open-ended concept was developed to gain more insight into the Latino/a adolescent's attitude towards suicide. Additionally, based on the reviews of the literature, one of the goals of the therapist is to identify factors that can be both risk and protective factors (i.e. familismo, acculturation, etc.) and discuss with the client ways to increase the protective qualities of each factor. Refocusing the client's thoughts into more positive cognitions, such as thinking about goals, can also encourage hope and finding ways to use those pieces as protective factors. In this activity, the client is asked to write on a blank sheet of paper and list things that are important to them. Examples can be family, school, boy/girlfriend, pets, future goals, etcetera. The therapist can also bring up factors that are more culturally relevant to the individual, such as importance of heritage, or language.
2. Wheel of Support. This is an activity where therapists instruct the client to consider individuals or resources they can go to for support when feeling suicidal or depressed. This can be used as the therapist and client start to develop a Crisis Plan (which is

explained next). This activity is based on the strong research supporting the need to identify and connect the client to supports and incorporate them into the therapy as much as possible. For this activity, clients are instructed to write their name in the middle of a sheet of paper and around their name, write names of people, groups, or other resources they can connect to. This can include crisis hotlines and Smartphone Apps as well.

3. **Crisis Plan.** This worksheet was developed based on crisis assessment with high risk adolescents (Miller, Rathus, Linehan, 2007) as part of a DBT-based intervention to help the client identify when they are in crisis and have a concrete plan of what to do when in crisis. This worksheet will be adjusted to focus on suicidal thoughts and/or behaviors. Some of the prompts include the name of the therapist, times they are available, contact information of three other individuals they can call or resources such as a crisis hotline, warning signs/triggers of that individual, self-assessment of suicidality (ideation/means/plan), means removal, coping skills they can apply during crisis, phrases of empowerment, and when to call 911. Phrases of empowerment can be quotes or sentences the client finds as a good reminder that they have control and power over their behaviors. This activity can be completed individually with the client and if appropriate, include family members in the plan so they are also informed and can provide support. A Spanish version of the plan can also be provided to increase access to care.
4. **Family Roles.** A consistent and clear theme that arises repeatedly is the need to include the family as often as possible when treating Latino/a adolescents with suicidal thoughts. Inclusion of family and building more collective and cohesive support can facilitate family cohesion, as well as provide psychoeducation to family members about how to most effectively respond to the adolescent if/when they feel suicidal. Therefore, this



activity is a collaborative effort where each member of the family is assigned a role in provided ongoing help, support, and care for the adolescent. For example, the adolescent's role can include attending therapy, communicating when they are not feeling safe or when they need something. The role for a parent can include providing positive feedback, attending family sessions, and learning more about suicide. Siblings, including children, can also be included such as choosing fun activities the family can do together. This is something the family can discuss in session with the clinician and write down what each person's role will be.

5. **Supportive Phrases.** This worksheet is primarily intended for parents and caregivers. It explains how phrases encouraging trust and safety can assist the adolescent instead of isolation. Based on stigmas and negative beliefs around suicide, parents may have a difficult time knowing how to respond when their child says they are suicidal. Often, parents can unintentionally respond in ways that further isolates the adolescent and can increase their risk. This worksheet provides phrases parents can use to replace common negative-toned sentences. The bottom end has blank spaces for parents to fill out and think of replacement phrases on their own. Clients can also contribute by communicating what they would like to hear as well. This practices good interpersonal skills, communication, and family positivity—all of which other EBP's focus on when providing effective intervention.
6. **Religion and prayer.** Research may still be limited when it comes to analyzing religion and suicide amongst Latinos/as, however it can potentially be beneficial to incorporate religious (e.g. Catholic) beliefs of the client and/or family as a way to connect to additional support. The degree to which an adolescent and family members may be

practicing a religion can also vary. As such, facilitating a discussion about religion and their connection to it is important. Some questions to ask can include how is religion impacting (if at all) their well-being? Do they identify with any religion at all? Is it something they consider a stressor? Is it something they see as positive and helpful? If the client finds it helpful, developing their own prayer for when they are in crisis or feel they need spiritual support can be an activity done in therapy.

The end of the manual will include resources that mental health providers can use to gain more understanding, expertise, and resources to further provide individualized treatment for each client.

## **Chapter V: Discussion**

The current dissertation involved the development of a Resource Manual for mental health practitioners working with Latino/a adolescents who endorse suicidal ideation and/or behaviors through the evaluation of the research literature exploring risk and protective factors of Latinos/as and suicidality as well as EBP's for treating suicide and adolescents. Most notably, the literature review process revealed the commonalities that both areas shared; many interventions on some level already addressed factors that strongly related to the Latino/a community (i.e. increasing family support, and improving treatment adherence). The literature, however, had limited evidence that positively links the two to determine efficacy. The goal of the Resource Manual is to begin the process of closing the gap by first starting with a resource that clinicians can utilize and research. As such, the study has some limitations, such as the manual not yet being validated. It is hoped that future revisions of this Resource Manual can be used to inform practitioners of the unique issues relevant to Latino/a adolescents with suicidal ideation and possible intervention strategies that can be incorporated into treatment.

### **Limitations and Recommendations**

In doing so, there are limitations to this study that must be discussed. As previously stated, the Resource Manual was developed as a preliminary step in developing a more focused and culturally-appropriate guide to for mental health professionals to integrate into their practice. As such, the primary focus when doing the literature review was to explore interventions in mental health-based settings. Interventions that also take place in other settings including schools and emergency rooms in hospitals were not included. Results of studies that examine programs, such as school-based interventions, are currently inconsistent with their findings with their true efficacy. It becomes challenging, therefore, to incorporate school-based interventions and expand

the Resource Manual even further with undetermined data without losing focus of the manual's purpose. For future research, it would be helpful to develop ways of connecting various settings of the client (home, school, clinic), to increase awareness of warning signs and support for the client.

There are additional limitations of the manual that may limit the applicability of interventions. These limitations include the level of diversity within Latino/a adolescents which these interventions may be applied to. For example, a large majority of interventions address the need to decrease isolation and utilize the value of family to connect adolescents to a more meaningful support system. This can be challenging with youth who may not have a strong support with family or may lack the traditional family structure that is typically associated with familismo. Families with abuse, gang involvement, foster families, and violent neighborhoods can impact how an adolescent individual may or may not connect and reach out to their community for help. Much of the literature does not address these particular issues. The lack of resources offering culturally adapted exposure treatments limit the information available to develop these adaptations in the Resource Manual. This highlights the need for more studies that investigate cultural modifications to evidenced-based treatments, such as problem-solving and family-focused therapy. Where there is a limitation in one area, however, there is a need to increase the strength of the protective factors that are present for that adolescent. For example, building a strong collaborative relationship between the therapist and client becomes even more essential in establishing enough trust to discuss these potential challenges with them.

Furthermore, given the brief nature of the guide and the intention for it to be applied to existing treatment formats (i.e. group, individual, family) and protocols, clinicians may need to be more experienced in other interventions and only use this as an adjunct or as a supplemental

guide to inform current treatment. Moreover, some of the worksheets may be challenging to complete for those of lower education. Although they are written to be understood by a wide audience, often times the idea of “completing worksheets” may be a less familiar practice for Latino/a clients (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011).

Finally, modifications to strengthen the usefulness of the Resource Manual can happen once the manual is examined more closely reviewed and validated. Potential ways to improve the manual is to include additional graphics and visual tools. Integrating technology into the interventions is another additional suggestion. For example, incorporating the My3 mobile app that asks the user to list their immediate three contacts to use when in crisis can be incorporated in the the Circle of Support intervention to make it more easily available.

Recommendations for future study is to conduct a formal exploratory review of the manual by mental health professionals to provide constructive feedback about its practicality and applicability to the population it aims to serve. A revised Resource Guide could then serve as the basis for conducting an implementation study in which the content and structure of the Resource Guide could be tested with a small group of clinicians who would integrate the guide into their treatment procedures. The Resource Guide would be further adapted based upon feedback from the clinicians, as well as possibly the individual clients. This study would potentially offer additional identification of strengths, weaknesses, and areas for improvement.

### **Plan for Future Study**

The next step for this manual is to test it in the community and receive feedback regarding its usability. Experts in the field who regularly treat Latino/a adolescents can provide feedback through structured interviews following the review of the manual and/or attending a workshop as part of professional growth. Consulting with these experts can inform and further

support needed modifications based on their real world experiences in working with this population. Following analysis from field experts and modification, the manual can then be applied with clients. Pre and post assessments can assist in determining if there is a difference in decreasing the risk of suicide following treatment with the incorporation of the manual.

### **Conclusion and Implications of the Study**

While the occurrence of therapy clients completing suicide is relevantly rare, the high risk of suicidality for this population cannot be minimized, much less ignored. Without these targeted prevention efforts, the high rates of suicidal behavior among Latino/a adolescents will not change. This not only impacts the adolescent, but it is also clear that it impacts the people around them, most notably, their families. As such, awareness of the issue by a mental health practitioner can improve their ability and flexibility in more effectively supporting the client they are treating. The responsibility is not to predict a suicide attempt; however, it is the practitioner's responsibility to guide and be adaptive to the issues and strengths that each individual will exhibit. Suicidality can be a difficult and even scary topic for the client, their families, and even the practitioners themselves. But with increased awareness and discussion about the topic, the stigma can be minimized, and the hope provided in effective treatments can be highlighted.

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## APPENDIX A

## Resource Manual

**Introduction**

As practitioners, it can be challenging at times to juggle and manage all of what is required of us. This becomes especially true when a client comes into crisis and is considering suicide. The fact that they are willing to seek out help demonstrates that there is still some form of hope, however small it may be. Our role as therapists is to assist the client in strengthening their hope and connecting them to the help they need. That is the goal of this resource manual—to build hope. This can be even more difficult to do when there are limited resources for a particular population. This manual was, therefore, developed as a guide that builds on your previous training and current competence in addressing suicidality so that you can more effectively provide culturally-tailored intervention to Latino/a adolescents who endorse suicidal behaviors.

This manual is divided into four main sections: 1. Rationale and Use of the Resource Manual 2. Risk and Protective Factors for Latino/a Adolescents 3. Themes within Evidence-Based Practices for Suicidal Adolescents 4. Integration of the Literature and In-Session Activities for Clinicians.

**Disclaimer.** This manual was developed to be used as a supplemental guide clinician can use when treating suicidal clients. It is in no way designed or intended to replace any interventions, especially when immediate action is required. If the client is in an crisis that requires an immediate response, please call 911. The clinician will use their professional clinical judgment to determine appropriate and ethical responses to clients who endorse suicidality. Additionally, the clinician must recognize and be aware of how cultural factors may relate to the individual *in*

*addition* to other factors that are impacting the client's mental well-being. "Race does not provide an adequate explanation of the human condition" (Sue et al., 2009); the clinician must, therefore, use caution when using any culturally-adapted tool as it should not be used to replace the other essential pieces that complete the conceptualization of an individual.

### **Definition of Terms**

For the purposes of clarity, the definitions of Latino/a, Adolescence, and Suicide are provided below:

- **Latino/a:** The U.S. 2010 Census defines it as "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race." It adds that Hispanic origin "can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival to the United States" (para. 1). Additionally, Latino/a as a category is best seen as pan-ethnic and certainly very heterogeneous, in the sense that it encompasses a range of cultures, racial backgrounds, national origins, and other important dimensions of diversity (Delgado & Stefancic, 2001).
- **Adolescence:** Arnett (2010) combines historical, theoretical, and contemporary research to define adolescence specifically as the period spanning from ages 10-18. Given that the adolescence age span falls within the range where suicide is at its highest risk, Arnett's definition of adolescence is most appropriate for the purposes of this manual. It should be noted that this definition still comes from an individualistic view and can be perceived differently when working with cultures from a more collective family-focused perspective, including the Latino/a culture. As such, it is important to consider how these

cultural aspects can influence how adolescence between this ages group is perceived to them and their families.

- **Suicide:** suicidality includes behaviors related to suicide, such as suicide attempts, planning, gaining access to means, and suicidal ideation (including passive and active thoughts).
- **Evidence-Based Practice:** Based on the American Psychological Association (APA) Presidential Task Force (2006), Evidence-Based Practice in Psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. The purpose of EBP is to promote effective mental health practices and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention (APA, 2006). For suicide prevention, positive outcomes are reductions in suicidal behaviors or changes in suicide-related risk and/or an increase in protective factors. Cognitive Behavior Therapy (CBT) most commonly falls under this category since its objective and structured approach makes it attractive for researchers trying to gain an objective and clear result. Some other interventions include family therapy, Dialectical Behavior Therapy (DBT), Interpersonal Therapy (IPT), and psychodynamic therapy.

### **Rationale and Use of the Resource Manual**

Suicide in the United States is a topic that can impact a person at any point throughout their life. For clinicians who plan to use this manual, there is some recognition that Latino/a adolescents are at some level of risk for suicide and that cultural factors can impact their risk. To

help clinicians understand just what exactly that risk, it is important to review the current statistics.

- For adolescents, the ranking of suicide increases significantly higher than the general population; Suicide is the third leading cause for children ages 10-14 and the second leading cause for ages 15-24 (Center for Disease Control [CDC] WISQARS, 2011).
- The Center for Disease Control and Prevention revealed that each year in the United States, approximately 2,000 to 2,500 adolescents under the age of 20 complete suicide.
- 100-200 suicide attempts are made for every one completed suicide amongst this age group (Goldsmith, Pellmar, Kleinman, & Bunney, 2002).

For Latino/a adolescents, the statistics become even more concerning:

- Research shows that Latino/a youth are at an even greater risk for suicidal behavior than any other ethnic group in the U.S. (Canino & Roberts, 2001).
- According to Smokowski, Ferdon, and Stroupe (2009), “Significantly more Hispanic youth (12.8%) reported making a suicide plan in the past year than either non-Hispanic, White (10.8%) or non-Hispanic, Black (9.5%) students” (p. 243).

As the Latino/a population in the United States continues to rise, so does the need to address suicidality among its most susceptible people. Therefore, the need to develop effective and efficient intervention strategies for this high-risk population is immediate. Gaining an increased understanding of the cultural-specific issues that can increase or decrease their risk, and how we can incorporate these issues into interventions that already have evidence efficacy informed the development of this manual.

Any mental health clinician who frequently treats Latino/a youth can use the manual. Just as there is a diverse range of adolescent clients, however, there is also a diverse range of

professionals who treat them. Due to the high need for accessibility for both adolescents, especially adolescent Latino/a youth, limiting the range of qualified disciplines or types of competent professionals that can utilize this manual would be counterintuitive. Therefore, mental health providers with adequate training in ethical principles, competence in treating this population, can integrate information provided in this manual to their practice; types of professionals include psychologists, psychiatrists, psychology trainees, social workers, or License Marriage and Family Therapists (LMFT's). When treating a client with suicidal ideation or behaviors, it is always important that the ethical principles under the American Psychology Association (APA) be followed.

### **Risk and Protective Factors for Latino/a Youth and Suicidality**

This section presents data from the current literature about the risk factors and identifying individuals who are at high risk for having suicidal thoughts and/or intent. This also includes protective factors that are unique and/or can overlap with some of the stated risk factors that are important to consider when assessing and determining appropriate treatment interventions. These are detailed below:

- **Cultural attitude towards mental health.** Inquiring about the cultural perceptions of mental health, especially among the family can impact how involved that individual and their support system can be in their treatment. Many families still hold a stigma and lack trust within the system, making them reluctant and untrusting of disclosing any need for professional help. Establishing strong rapport and trust can help build more positive attitudes toward seeking out professional help.

- **Cultural attitude towards suicide.** Inquiring about the individual and their culture's perception of suicide provides insight for the therapist and the client of what thoughts and hesitations around stigma might be limiting or encouraging their use of resources to their fullest potential.
- **Help Seeking Behaviors.** Much like cultural attitudes toward mental health, the mental health professional's increased awareness of patterns and tendencies of where adolescents go to seek help when they decided to do so is helpful in appropriately addressing treatment and correct psychoeducation. Latino/a adolescents tend to approach family and friends before seeking other professionals such as therapists or teachers.
- **Access to care.** Various studies have shown that access to mental health care is a noted challenge at times for various reasons, including transportation, lack of knowledge, or language barriers. This is particularly true for the parents and caregivers of adolescents. It therefore emphasizes the need in diversifying how mental health care is provided to best accommodate their needs, such as providing services at home, school, etc. At the very least, a greater effort is needed on the part of the provider to initiate and engage in a discussion with the adolescent and their family to address potential concerns and collaborating to problem-solve ways of addressing those barriers.
- **Immigration, assimilation, and acculturation.** There are many pieces and elements within the scope of impact that immigration and acculturation plays on families. Because of the complexity of these issues alone, it is imperative that mental health care professionals engage in some conversation with the adolescent

to discuss how these issues may or may not impact them and contribute to their stress.

- **Latinas.** Awareness of the issues and higher risk of Latina adolescents is important when the client identifies as such. This not only is an important step when assessing for suicidality, but in asking questions about their experience as a Latina can validate their experience and provide a safer space as a result.
- **Cultural Expression of Distress.** Different cultures express and communicate their distress in various ways. Research commonly notes that somatic symptoms can indicate the presence of psychological distress. Following evaluations from medical providers, Inquiring about triggers or pain and prior forms of treatment can provide essential detail if their distress is related to psychological pain that is impacting their daily functioning.
- **Discrimination.** Given that research has found discrimination to predict self-esteem, and self-esteem to predict depressive symptoms, it is important to consider self-esteem as a mediator when examining the relation between discrimination and depression.
- **Religion.** Determining whether religion plays a factor in a person's likelihood to engage in self-destructive behaviors, such as substance use, has been explored. For suicide specifically, the data is very limited, but does show some possible effect in it, especially with Catholicism, changing the help-seeking behaviors of immigrant Latinos/as specifically. Discussing or incorporating traditionally Catholic beliefs, prayers, or groups can be beneficial in providing a positive safe

space for adolescents and their families. Discussion of the role religion plays on the individual is encouraged.

### **Themes within Evidence-Based Practices for Suicidal Adolescents**

This section provides the mental health provider with common themes that arose after evaluating evidence-based strategies that show the most potential in effectively treating this population. These themes fall within three main stages of suicide intervention: 1. Assessment of Suicidality 2. Safety Planning and Treatment, and 3. Follow-Up and Reassessment of Risk.

The first stage is focused on **Assessment**, while considering the cultural risk and protective factors for that individual. Asking specific questions, especially related to their perception of death, suicide, and mental health, can not only help provide essential information for assessing risk to the therapist, but also begin to build trust and strong rapport. Developing good rapport with this population is shown to be essential in increasing the person's willingness to share candidly and will improve the likelihood that the individual will follow through with treatment. Research has shown that the client-therapist relationship is absolutely important for both adolescents and Latino/a populations. In addition, assessing for history of nonlethal suicidal behaviors or self-harm as it is a strong predictor for suicide in adolescents.

Using assessment scales are also useful tools to incorporate as part of the assessment stage. The majority of instruments that have been studied the most are primarily CBT-based self-report scales. A useful resource where therapists can familiarize themselves with current assessment instruments for adolescent suicide is provided by the Suicide Prevention Resource Center. The link is provided in the Resources section of the Appendix.

The second stage is **Safety Planning and Treatment**. The common themes that arose for this stage include the following:



- Brief interventions for addressing crises were found to be much more effective.  
Adolescents who seek treatment following suicidal behaviors tend to drop out of treatment earlier. Applying interventions that are brief not only better address the immediate crisis that is triggering those behaviors, but can improve the likelihood that adolescents will complete the entire therapy.
- Taking time to build strong connectedness and rapport with adolescent clients is an important step that should not be rushed through and is in itself an effective intervention.
- Applying and taking a skills-building approach, including guidance in problem-solving strategies, improves the accessibility and reduces the impression of stigma or judgment of the adolescent's suicidal thoughts or behaviors. Examples include CBT-SP and PST.
- Including family involvement is key for this population, which consists with the larger picture that finding and adding elements of support for the client improves their safety. While home-based family therapy shows mixed results, considering how to improve access to care is an important discussion to have when incorporating family and members for support.
- Improving easy accessibility to treatment, especially during a crisis, is essential. Providing resources to crisis hotlines or smartphone apps have been effective strategies for this population in particular.
- Growing research shows that means reduction is one of the most effective interventions. During the assessment phase, if a plan and means have been identified, part of the safety planning is to remove the individual's access to those means. Challenges with reducing certain means can arise, such as removing prescription medication for medical purposes.

Discussing a plan with the client and family can be helpful in collaborating together to navigate around those challenges (e.g. give medication to a family member who can closely monitor dosage).

- Emerging research for Latino/a-focused therapy for suicidal adolescents is starting to arise. Certain characteristics of these interventions show potential and promise in their ability to reduce risk. These include themes of empowerment and family inclusion. Given the historical and societal context of oppression and Latinos/as in the United States, empowerment is especially important in increasing for this community. Both of these themes should be considered and incorporated in therapy.

The last part is **Follow-up and Reassessment**. Much of the themes that arose in the prior two sections can be done to follow-up and reassess risk. The literature highlights the importance in maintaining skills learned in therapy and prolonging the efficacy after treatment. If possible is recommended that the therapist schedule less frequent follow-up appointments to check-in and reassess for risk. Whether this the clinician is able to follow-up or not, it is important to provide the client with resources that they can utilize and continue to utilize after treatment is completed. Discussing the potential outcomes and the honest possibility that symptoms can return should also be explored with the client.

### **Culturally-Tailored Activities for Therapy**

Six concrete interventions were developed based on these on strategies, with consideration of risk and protective factors of Latino/a adolescents. These interventions will be described and explained for therapists to utilize in their own practices when addressing suicidality with clients. Examples are also included.

1. **Things to live for list.** Inspired by the assessment inventory, Reasons For Living-

Adolescents (RFL-A) based on the DBT perspective, a more open-ended concept was developed to gain more insight into the Latino/a adolescent's attitude towards suicide.

Additionally, based on the reviews of the literature, one of the goals of the therapist is to identify factors that can be both risk and protective factors (i.e. familismo, acculturation, etc.) and discuss with the client ways to increase the protective qualities of each factor.

Refocusing the client's thoughts into more positive cognitions, such as thinking about goals, can also encourage hope and finding ways to use those pieces as protective factors.

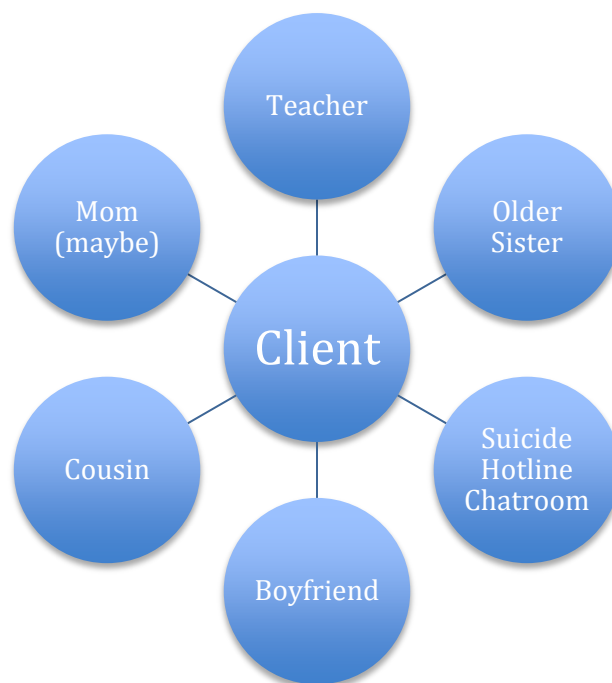
In this activity, the client is asked to write on a blank sheet of paper and list things that are important to them. Examples can be family, school, boy/girlfriend, pets, future goals, etcetera. The therapist can also bring up factors that are more culturally relevant to the individual, such as importance of heritage, or language.

Example:

Family	School	Goals
<ul style="list-style-type: none"><li>• Pet</li><li>• Younger Sister</li></ul>	<ul style="list-style-type: none"><li>• Friend</li><li>• Basketball team</li></ul>	<ul style="list-style-type: none"><li>• Go to college</li><li>• Become a teacher</li><li>• Provide for family</li></ul>

2. **Wheel of Support.** This is an activity where therapists instruct the client to consider individuals or resources they can go to for support when feeling suicidal or depressed. This can be used as the therapist and client start to develop a Crisis Plan (which is explained next). This activity is based on the strong research supporting the need to identify and connect the client to supports and incorporate them into the therapy as much as possible. For this activity, clients are instructed to write their name in the middle of a sheet of paper and around their name, write names of people, groups, or other resources they can connect to. This can include crisis hotlines and Smartphone Apps as well. This can be helpful in recognizing factors that make the client willing to approach some and not others. Clinicians can use this to facilitate a more in-depth discussion of the client's attitude towards asking for help from certain individuals and addressing potential distorted cognitions that may arise.

Example:



3. **Crisis Plan.** This worksheet was developed based on crisis assessment with high risk adolescents (Miller, Rathus, Linehan, 2007) as part of a DBT-based intervention to help the client identify when they are in crisis and have a concrete plan of what to do when in crisis. This worksheet will be adjusted to focus on suicidal thoughts and/or behaviors. Some of the prompts include the name of the therapist, times they are available, contact information of three other individuals they can call or resources such as a crisis hotline, warning signs/triggers of that individual, self assessment of suicidality (ideation/means/plan), means removal, coping skills they can apply during crisis, phrases of empowerment, and when to call 911. Phrases of empowerment can be quotes or sentences the client finds as a good reminder that they have control and power over their behaviors. This activity can be completed individually with the client and if appropriate, include family members in the plan so they are also informed and can provide support. A Spanish version is also provided to increase access to care.

### **My Crisis Plan**

Name: \_\_\_\_\_

Instructions: Complete this worksheet with your therapist and have a copy with you to help guide you when you feel you are in crisis.

1. Other People I Can Call for Support
1. 2. 3.
2. Warning signs/triggers

Example: bad grades, fight with parents, change in mood, isolation

### 3. Self-assessment of suicide

These are questions you can ask yourself if you feel you are in crisis:

- Do I have thoughts of suicide?
- Do I have a plan of how I would do it? If yes:
  - What is my plan?
  - What do I plan to use? Can I get it easily?
  - When do I plan to act on it?\*

\*If you plan to act today, call 911 or go to the nearest emergency room

### 4. Self-Assessment Scale

To be done when you feel you are in crisis.

On a scale from 1-5, where would you rate yourself?

Just thoughts 1-----2-----3-----4-----5\* I plan to do it  
Today

\*If you self-rated a 5, please call 911 or go to the nearest Emergency Room

### 5. Coping Skills to Help Calm Me Down.

### 6. Positive Phrases that Empower Me.

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7. My Therapists Name, phone number, and times of availabilities for calls.

## Mi Plan de Crisis

Nombre: \_\_\_\_\_

Instrucciones: Completa esta actividad con su terapeuta y guarda una copia contigo para guiarte cuando estés en crisis.

8. Otras personas que puedo llamar
1.
2.
3.

9. Señales de advertencia
Ejemplos: Calificaciones bajas, argumento con tus padres, cambios del estado anímico, aislamiento

10. Auto-evaluación del suicidio
Estas son preguntas que puedes hacer a ti mismo cuando estés en crisis:
<ul style="list-style-type: none"><li>• ¿Tengo pensamientos de suicidio?</li><li>• ¿Tengo un plan? Si la respuesta es “sí”:<ul style="list-style-type: none"><li>○ ¿Cuál es mi plan?</li><li>○ ¿Qué voy a usar para completarlo? ¿Puedo conseguir esas cosas?</li><li>○ ¿Cuándo lo voy a hacer?*</li></ul></li></ul>
*Si piensas hacerlo hoy, llama al 911 o visita la sala de emergencia más cercana

11. Escala de auto-evaluación
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En una escala entre 1 y 5, ¿dónde te clasificarías?

Solo pensamientos 1-----2-----3-----4-----5\* Lo haré hoy

\* Si piensas hacerlo hoy, llama al 911 o visita la sala de emergencia más cercana

12. Actividades para calmarme

13. Frases positivas para sentirme empoderado

14. Nombre de mi terapeuta, numero de teléfono, y horas de disponibilidad

4. **Family Roles.** A consistent and clear theme that arises repeatedly is the need to include the family as often as possible when treating Latino/a adolescents with suicidal thoughts. Inclusion of family and building more collective and cohesive support can facilitate family cohesion, as well as provide psychoeducation to family members about how to most effectively respond to the adolescent if/when they feel suicidal. Therefore, this activity is a collaborative effort where each member of the family is assigned a role in provided ongoing help, support, and care for the adolescent. For example, the adolescent's role can include attending therapy, communicating when they are not feeling safe or when they need something. The role for a parent can include providing positive feedback, attending family sessions, learn more about suicide. Siblings, including children, can also be included such as choosing fun activities the family can do together. This is something the family can discuss in session with the clinician and write down what each person's role will be.
5. **Supportive Phrases.** This worksheet is primarily intended for parents and caregivers. It explains how phrases encouraging trust and safety can assist the adolescent instead of isolation. Based on stigmas and negative beliefs around suicide, parents may have a difficult time knowing how to respond when their child says they are suicidal. Often, parents can unintentionally respond in ways that further isolates the adolescent and can increase their risk. This worksheet provides phrases parents can use to replace common negative-toned sentences. The bottom end has blank spaces for parents to fill out and think of replacement phrases on their own. Clients can also contribute by communicating what they would like to hear as well. This practices good interpersonal skills,

communication, and family positivity—all of which other EBP's focus on when providing effective intervention. Below is a worksheet that can be completed in a family session with the client and the family member in English and Spanish:

### Positive Phrases

Isolation is one of the biggest triggers for suicidal thoughts, especially for teens. When teens say they are feeling suicidal, sometimes we respond in ways that make teens feel more alone and isolated, even when we did not mean to. Here are some isolating phrases that can be changed to make a person feel supported and more willing to seek help.

Type of negative phrases	Positive Phrases
Shaming: -“Don’t feel that way, it’s wrong.”	“I’m really glad you told me”
Minimizing feelings: -“Don’t be so overdramatic.” -“Get over it.”	“I know you are in a lot of pain.”
Isolating: -“Other people have it worse than you.” -“You’re crazy.”	“I’m hear to support and listen. Let’s work together to get you the help you need.”

What are some phrases that you can think of, what can be said instead? Work with the family to discuss what the client would like to hear as well from their loved ones.

Other negative phrases:	Replacement Phrase:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- Religion and prayer.** Research may still be limited when it comes to analyzing religion and suicide amongst Latinos/as, however it can potentially be beneficial to incorporate

religious (e.g. Catholic) beliefs of the client and/or family as a way to connect to additional support. The degree to which an adolescent and family members may be practicing a religion can also vary. As such, facilitating a discussion about religion and their connection to it is important. Some questions to ask can include how is religion impacting (if at all) their well-being? Do they identify with any religion at all? Is it something they consider a stressor? Is it something they see as positive and helpful? It can be used to help the client explore their own values and identifying potential positive aspects in their lives they may not have considered. If the client finds it helpful, developing their own prayer for when they are in crisis or feel they need spiritual support can be an activity done in therapy.

### **Additional Resources**

PRACTICE GUIDELINE FOR THE Assessment and Treatment of Patients With Suicidal Behaviors

[http://psychiatryonline.org/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/suicide.pdf](http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf)

Suicide Prevention Resource Center: Suicide Screening and Assessment

[http://www.sprc.org/sites/default/files/migrate/library/RS\\_suicide%20screening\\_91814%20final.pdf](http://www.sprc.org/sites/default/files/migrate/library/RS_suicide%20screening_91814%20final.pdf)

Information about suicidality and treatment approaches:

Suicide Prevention Resource Center: [www.sprc.org](http://www.sprc.org)

SAMHSA's National Registry of Evidence-based Programs and Practices:

<http://www.nrepp.samhsa.gov/>

(type in suicide in search box, age group: adolescents)

Suicide Prevention Line:

1-800-273-8255 (English/Español, 24 hrs)

Direct Spanish number: 1-888-628-9454

Online Chat (24 hours):

[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org) and click the button that says "Click to Chat"

Smartphone Apps:

A Friend Asks (provides information about warning signs and how to reach out to them.)

My3 (helps you build a safety plan and directly connects you to your safety contacts.)

Stay Alive (more psychoeducation about suicide.)

APPENDIX B:

IRB Approval Letter

# PEPPERDINE UNIVERSITY

## Graduate & Professional Schools Institutional Review Board

April 24, 2017

Rebecca Gutierrez

Project Title: Providing Hope: A Systematic Development of a Resource Manual for Mental Health Professionals Treating Latino/a Adolescents with Suicidal Ideation  
Re: Research Study Not Subject to IRB Review

Dear Ms. Gutierrez:

Thank you for submitting your application, *Providing Hope: A Systematic Development of a Resource Manual for Mental Health Professionals Treating Latino/a Adolescents with Suicidal Ideation*, to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). After thorough review of your documents you have submitted, the GPS IRB has determined that your research is not subject to review because as you stated in your application your dissertation *research* study is a "critical review of the literature" and does not involve interaction with human subjects. If your dissertation research study is modified and thus involves interactions with human subjects it is at that time you will be required to submit an IRB application.

Should you have additional questions, please contact the Kevin Collins Manager of Institutional Review Board (IRB) at 310-568-2305 or via email at [kevin.collins@pepperdine.edu](mailto:kevin.collins@pepperdine.edu) or Dr. Judy Ho, Faculty Chair of GPS IRB at [gpsirb@pepperdine.edu](mailto:gpsirb@pepperdine.edu). On behalf of the GPS IRB, I wish you continued success in this scholarly pursuit.

Sincerely,



Judy Ho, Ph. D., ABPP, CFMHE  
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives  
Mr. Brett Leach, Compliance Attorney  
Dr. Carrie Castañeda-Sound, Faculty Advisor